Supreme Court, U.S.
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No. 94-2134

IN THE

# Supreme Court of the United States

OCTOBER TERM, 1994

GEORGE PETERSON,
*Petitioner,*
*vs.*
AMERICAN LIFE & HEALTH INSURANCE COMPANY, CREATIVE HEALTH PROGRAMS; PACIFIC SOUTHWEST ASSOCIATION OF SMALL EMPLOYER FIRMS,
*Respondents.*

PETITION FOR WRIT OF CERTIORARI
TO THE UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

## PETITION FOR WRIT OF CERTIORARI

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## QUESTION PRESENTED

1. Does the Employee Retirement Income Security Act of 1974 confer federal court jurisdiction over an action for recovery of insurance benefits under a policy of insurance held solely by an owner/employer, and preempt his state law causes of action?

## LIST OF PARTIES TO THE PROCEEDINGS

The parties to this proceedings are all listed in the caption of this case. The Petitioner, George Peterson, is an individual.

No appeal was taken from the dismissed claims against Mr. Richard Reynolds, and he is not a party to this proceeding, nor was he a party in the court below.

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No. _____

In The
SUPREME COURT OF THE UNITED STATES
October Term, 1994

GEORGE PETERSON,
*Petitioner,*
*vs.*
AMERICAN LIFE & HEALTH INSURANCE COMPANY, CREATIVE HEALTH PROGRAMS; PACIFIC SOUTHWEST ASSOCIATION OF SMALL EMPLOYER FIRMS,
*Respondents.*

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# PETITION FOR WRIT OF CERTIORARI

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The Petitioner, Mr. George Peterson, respectfully requests and seeks certiorari to review the judgment of the United States Court of Appeals for the Ninth Circuit.

## I.

## OPINIONS BELOW

The opinion of the United States Court of Appeals for the Ninth Circuit is reported at 48 F.3d 404 (9th Cir. 1995), and is reprinted in Appendix A. The opinion of the District Court granting the insurer's summary judgment motion was not reported, but is also reprinted in Appendix C. The opinion of the District Court denying

remand of the action to California state court, and dismissing all state law claims, is reprinted in Appendix D.

## II.

## STATEMENT OF JURISDICTION

The United States Court of Appeals for the Ninth Circuit denied petitioner's timely petition for rehearing and for rehearing *en banc* on April 6, 1995. (Appendix B.) Petitioner seeks review of this judgment. The jurisdiction of this Court is invoked pursuant to 28 U.S.C. § 1254(1).

## III.

## CONSTITUTIONAL AND STATUTORY PROVISIONS INVOLVED

This case requires the Court to analyze the preemptive scope of the Employee Retirement and Security Act of 1974 (hereinafter "ERISA"), 29 U.S.C. § 1001 *et seq.* as same applies to the owner/employer of a business providing insurance solely for himself, but which has covered an employee in the past. Pertinent portions of the statutes at issue are cited here, and the full text of each is printed in the appendix, as noted.

The pertinent portion of 29 U.S.C. § 1132 states that: "A civil action may be brought — (1) by a participant or beneficiary — . . ." (Appendix E.)

29 U.S.C. § 1002(7) defines "participant" as "any employee or former employee of an employer, or any member or former member of an employee organization, who is or may become eligible to receive a benefit of any type from an employee benefit plan which covers

employees of such employer or member of such organization, or whose beneficiaries may be eligible to receive any such benefit." (Appendix F.)

29 U.S.C. § 1002(8) defines "beneficiary" as "a person designated by a participant, or by the terms of an employee benefit plan, who is or may become entitled to a benefit thereunder." (Appendix F.)

29 U.S.C. § 1103(c)(1) states that ". . . the assets of a plan shall never inure to the benefit of any employer and shall be held for the exclusive purposes of providing benefits to participants in the plan and their beneficiaries. . . ." (Appendix G.)

29 C.F.R. § 2510.3-3(c)(2), which clarifies who is an "employee" under ERISA, provides: "A partner in a partnership and his or her spouse shall not be deemed to be employees with respect to the partnership." (Appendix H.)

## IV.

## STATEMENT OF THE CASE

### A. Basis for Federal Jurisdiction

This is the question at issue in this case. The U.S. District Court for the Central District of California and the U.S. Court of Appeals for the Ninth Circuit held that federal jurisdiction pursuant to ERISA existed because Mr. Peterson, a partner in an unincorporated business, was seeking benefits allegedly due him under an insurance policy paid for by his business, which had, at one time in the past, covered one employee in addition to Mr. Peterson.

### B. Petitioner's Background and Factual Allegations

The insured is a partner of the business that paid for his insurance. At the time of the surgery for which he seeks benefits, no employee or other person associated with that business was covered under the American Life policy.

### C. Procedural History

This action was originally filed in the Superior Court of the State of California, on February 13, 1991. The Complaint stated causes of action for Breach of Contract, Breach of the Implied Covenant of Good Faith and Fair Dealing, Negligence, and Breach of Oral Contract, under California law relating to insurance contracts. The defendants were American Life & Health Insurance Company ("American Life"), Creative Health Programs, Pacific Southwest Association of Small Employer Firms ("PSA"), and Richard G. Reynolds. The insured did not appeal for the dismissal of the claims against defendant Reynolds, the sole defendant in the Breach of Oral Contract Claim.

The Complaint was served on Defendant Reynolds on February 27, 1991, and was removed to the United States District Court on March 28, 1991. The sole ground asserted in the Notice of Removal was that the District Court had original jurisdiction of the action under the provisions of the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1001 *et seq.*

On April 2, 1991, Defendants moved to dismiss all claims in the Complaint on the grounds that same were preempted by the provisions of ERISA. On April 5,

1991, the insured filed a Motion to Remand the action to State Court on the grounds that as an owner/employer and the sole insured under the policy, no subject matter jurisdiction of the insured's claims could be found under ERISA. The District Court continued both motions to allow for discovery on the jurisdictional issues.

On October 7, 1991, the District Court denied the insured's motion to remand, finding that the American Life & Health Insurance policy was an employee welfare benefit plan, due to the fact that the insured's business paid the premiums for his policy. The District Court further found that although the insured was a partner in that business, and an owner/employer, his claims were preempted by ERISA due his status as a beneficiary under the American Life & Health Insurance plan. The District Court rested its decision on the decision of the U.S. Court of Appeals for the Ninth Circuit in *Harper v. American Chambers Life Ins. Co.*, 898 F.2d 1432 (9th Cir. 1990). The Court consequently granted defendants' Motion to Dismiss, with leave to amend. (Appendix D.)

The District Court elected to treat the case as one amenable to summary judgment. After hearing extensive oral argument by the parties, the District Court entered Summary Judgment for American Life on May 19, 1993. In doing so, the District Court confirmed its prior determination that Mr. Peterson's claim for benefits was governed by ERISA, and that all state law causes of action were dismissed. (Appendix C.)

Mr. Peterson timely appealed, and noted to the U.S. Court of Appeals for the Ninth Circuit that its decision in *Harper v. American Chambers Life Ins. Co.*, 898 F.2d 1432 (9th Cir. 1990) had been adopted by no other court, and was in conflict with every other U.S. Court of Appeals and a state court of last resort within its own territory that had decided the issue of whether an employer could recover benefits under an ERISA plan. The

U.S. Court of Appeals upheld its decision in *Harper* on February 15, 1995 (Appendix A), and issued an order declining to consider the matter *en banc* on April 6, 1995 (Appendix B).

## REASONS FOR GRANTING THE WRIT

### 1.

### THE NINTH CIRCUIT'S DECISIONS IN *HARPER* AND *PETERSON* ON THE ISSUE OF THE RIGHT OF AN OWNER/EMPLOYER TO SEEK ERISA BENEFITS AS A "BENEFICIARY" IRRECONCILABLY CONFLICTS WITH OPINIONS OF THE U.S. COURT OF APPEALS FOR THE SIXTH CIRCUIT AND THE COURT OF LAST RESORT FOR THE STATE OF NEVADA, AND HENCE, DESERVES THIS COURT'S ATTENTION PURSUANT TO U.S. SUPREME COURT RULE 10(a).

#### A. The Ninth Circuit's Decisions Directly Conflict With the Decision of the Sixth Circuit in *Fugarino* on the Same Issue.

In *Harper v. American Chambers Life Ins. Co.*, 898 F.2d 1432 (9th Cir. 1990) and *Peterson v. American Health & Life Ins. Co., et al.*, 48 F.3d 404 (9th Cir. 1995), the Ninth Circuit held that so long as a person was a beneficiary of an ERISA plan, it did not matter if that person was an independent contractor, owner, or employer. While such persons could not claim as "participants," their status as beneficiaries brought them into the fold.

In the Sixth Circuit, in *Fugarino v. Hartford Life and Accident Insurance Co.*, 969 F.2d 178 (6th Cir. 1992), *cert denied*, 113 S.Ct. 1401, 112 L.Ed.2d 774 (1993), the Court held that Mrs. Fugarino's state law claims were not preempted by ERISA, as she was the owner/ employer of the business purchasing health insurance for herself, her husband, and her employees, and "a fundamental requirement of ERISA is that 'the assets of a plan shall never inure to the benefit of any employer.' " (*Id.* at 185.) The Court found that (1) the insurance contract covering the Fugarinos was not an ERISA plan and (2) even if it was accepted to be part of an ERISA plan, the claims of Mrs. Fugarino, a nonemployee, were not preempted.

The Court reasoned that while an employer could never designate himself as a beneficiary in his employee's benefit plan, the employer still possessed common law contract rights with regard to his insurance contract.

Under the Ninth Circuit rule stated in *Harper v. American Chambers Life Ins. Co.*, 898 F.2d 1432 (9th Cir. 1990) and confirmed in *Peterson v. American Health & Life Ins. Co., et al.*, 48 F.3d 404 (9th Cir. 1995), dismissal of the Fugarino's state law claims was appropriate, as they were "beneficiaries" of an ERISA plan, along with other true employees, and ERISA provided their sole remedy.

Such a conflict between the Circuits is grounds for granting of this petition. *McElroy v. United States*, 455 U.S. 642, 643, 102 S.Ct. 1332, 1333, 71 L.Ed.2d 522 (1982), U.S. Supreme Court Rules, Rule 10(a.)

### B. The Ninth Circuit's Decisions Directly Conflict With the Supreme Court of Nevada's Decision in *Turnbow*.

In *Turnbow v. Pacific Mutual Life Ins. Co.*, 104 Nev. 676 (1988), *cert. denied*, 490 U.S. 1102, 109 S.Ct. 2458, 104 L.Ed.2d 1012 (1989), Ms. Turnbow's insurance policy also covered an employee of her business. The insurance company moved to dismiss Ms. Turnbow's state law-based action on the grounds it was preempted by ERISA. The Supreme Court of Nevada declined, noting that as an owner/employer, Ms. Turnbow was not an employee and was therefore entitled to seek relief in state court. (*Id.* at 676.)

Such a conflict, especially between a Court of Appeals and a state court of last resort within that very Court's territory, is also an appropriate grounds for granting this petition. U.S. Supreme Court Rules, Rule 10(a); *Baldwin v. Alabama*, 472 U.S. 372, 374, 105 S.Ct. 2727, 2729, 86 L.Ed.2d 300 (1985).

### C. The Conflict is Widening, and Will Not be Resolved Without This Court's Intervention.

The Ninth Circuit has had occasion to revisit *Harper v. American Chambers Life Ins. Co.*, 898 F.2d 1432 (9th Cir. 1990) and confirmed it in *Peterson v. American Health & Life Ins. Co. et al.*, 48 F.3d 404 (9th Cir. 1995), with full knowledge of the *Turnbow* and *Fugarino* decisions. This is despite the fact that *Harper* has never been cited with favor outside the Ninth Circuit. The Ninth Circuit's position on this issue is firm and unchangeable by the passage of time and the rejection of *Harper* by all other Courts.

*Harper v. American Chambers Life Ins. Co.*, 898 F.2d 1432 (9th Cir. 1990) has also been expressly criticized by two U.S. District Courts, who chose instead to follow *Turnbow v. Pacific Mutual Life Ins. Co.*, 104 Nev. 676 (1988), *cert. denied*, 490 U.S. 1102, 109 S.Ct. 2458 and *Fugarino v. Hartford Life and Accident Insurance Co.*, 969 F.2d 178 (6th Cir. 1992).

In *Kelly v. Blue Cross & Blue Shield of Rhode Island*, 814 F.Supp. 220 (D. Rhode Island, 1993), a Court within the First Circuit held that the *Harper* interpretation of the term "beneficiary" "would undermine ERISA's purpose of insuring that benefits not inure to employers." (*Id.* at 230, nt. 14.) Instead, the Court relied on *Fugarino*, as well as the reasoning of other U.S. Courts of Appeals in *Kwatcher v. Massachusetts Service Employees Pension Fund*, 879 F.2d 957 (1st Cir. 1989); *Meredith v. Time Ins. Co.*, 980 F.2d 352 (5th Cir. 1993); *Giardono v. Jones*, 867 F.2d 409 (7th Cir. 1989); and *Peckham v. Board of Trustees*, 653 F.2d 424 (10th Cir. 1981). (*Id.* at 227.) Each of those cases also held that the claims of an owner/employer are outside the scope of ERISA. The *Kelly* court also expressly adopted *Turnbow v. Pacific Mutual Life Ins. Co.*, 104 Nev. 676 (1988), *cert. denied*, 490 U.S. 1102, 109 S.Ct. 2458, and held that an owner/employer held nothing more and nothing less than state law causes of action where his or her insurance was at issue, despite the fact that employees were also covered under the policy. (*Id.* at 230.)

In *Madden v. Country Life Insurance*, 835 F.Supp. 1081 (N.D. Ill. 1993), a Court within the Seventh Circuit found that " . . . Harper strains credulity . . ." and expressly relied on the extensive analysis and cases found in *Kelly*. (*Id.* at 1086.) This Court too held that the owner/employer would be free to seek state law remedies available (if any) for the insurer's alleged breach of the insurance contract with him, with

knowledge of the fact that the contract also covered employees.

In *Brech v. Prudential Insurance Company of America*, 845 F.Supp. 829 (M.D. Ala. 1993), a Court within the Eleventh Circuit also accepted *Fugarino* and expressly adopted the holding of *Kelly* in determining that the insurance covering an owner/employer was not part of an ERISA plan, even though other employees were also covered under that same insurance contract.

The passage of six years since this Court denied the petition for certiorari in *Turnbow v. Pacific Mutual Life Ins. Co.*, 104 Nev. 676 (1988), *cert. denied*, 490 U.S. 1102, 109 S.Ct. 2458 (1989) have not served to bring about a consensus between the Circuits, or the Circuits and state courts of last resort, on the issue at hand. The Ninth Circuit has made clear that its opinion in *Harper* will stand, while an ever widening group of courts have made clear that they will continue to reject *Harper* just as strongly.

2.

## FEDERAL JURISDICTION AND ERISA PREEMPTION ARE ISSUES UPON WHICH NATIONAL UNIFORMITY IS NECESSARY AND WOEFULLY LACKING

As noted above, the Ninth and Sixth Circuits are diametrically opposed on the subject of ERISA preemption of an owner/employer's claims under an insurance contract. The Ninth Circuit and the Supreme Court of Nevada (which is within the Ninth Circuit's territory) are also irreconcilably conflicted on the subject of federal jurisdiction in such circumstances. Lower courts are considering the issue, and those which have, have also rejected the Ninth Circuit's view. Such a widespread,

continuing conflict is indicative of the importance of the issue at hand, and the appropriateness of resolution by this Court. *Heffron v. International Society for Krishna Consciousness*, 452 U.S. 640, 646, 101 S.Ct. 2559, 69 L.Ed.2d 298 (1981).

This is especially true where there is a question of federal jurisdiction which is the subject of the conflict between U.S. Courts of Appeals (*Bruner v. U.S.*, 343 U.S. 112, 114, 72 S.Ct. 581, 583, 96 L.Ed. 786 (1952)) or between a Court of Appeals and a state court of last resort. *Barker v. Kansas*, 503 U.S. 594, 597, 112 S.Ct. 1619, 118 L.Ed.2d 243, 249 (1992).

The need for national uniformity in determination of ERISA matters is recognized by this Court. *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 142, 111 S.Ct. 478, 112 L.Ed.2d 474, 486 (1990); *Shaw v. Delta Air Lines*, 463 U.S. 85, 99, 103 S.Ct. 2890, 2901, 77 L.Ed.2d 490 (1983). It is clear from the position of the Ninth Circuit, and the increasing attack on that position, that such uniformity will be established with regard to the ERISA claimant status of an owner/employer only when this Court provides guidance on this issue.

**3.**

## THE NINTH CIRCUIT'S DECISION IMPLIEDLY CONFLICTS WITH THIS COURT'S DECISION IN *DARDEN*

In *National Mutual Ins. Co. v. Darden*, 503 U.S. 818, 112 S.Ct. 1344, 117 L.Ed.2d 581 (1992), this court held that employees, not independent contractors and not agents, may bring ERISA claims. This case resolved a long standing area of confusion with regard to the persons entitled to bring an action for benefits under ERISA.

There, this Court reversed and remanded a granting of summary judgment in favor of the insurer where an arguably independent contractor had brought suit in federal court for recovery of ERISA benefits. An independent contractor was held to have no standing to sue as an ERISA plaintiff, even though he was a designated beneficiary. Remand was made to allow a factual determination of whether or not Mr. Darden was an independent contractor or an employee, under common law agency rules.

Under the Ninth Circuit's reasoning in *Harper v. American Chambers Life Ins. Co.*, 898 F.2d 1432 (9th Cir. 1990), a determination of Mr. Darden's status would hardly suffice to determine if he could make a claim for ERISA benefits. Instead, it would have to be proven that each and every person receiving benefits under the same plan as Mr. Darden was also an independent contractor. If there was one single employee covered, at any time since the plan's inception, *all* persons would be covered as ERISA "beneficiaries," whether employees or those claiming under them, or independent contractors. The factual questions and discovery needed to resolve same would be immense.

It is true that this Court did not consider whether Mr. Darden's beneficiary status alone would render him able to collect benefits. However, the wild result of such consideration is evident. The mere fact that there might be an employee somewhere at sometime who also was a participant in an ERISA plan is insufficient to provide claimant status to one who is not and has never been an employee and is not and has never been designated by an employee as his or her beneficiary, according to every court that has decided the issue with one exception — the Ninth Circuit.

## 4.

## CONCLUSION

For the reasons stated herein, petitioner respectfully requests that a writ of certiorari issue to review the judgment of the United States Court of Appeal for the Ninth Circuit.

DATED: June 27, 1995.

Respectfully submitted,

SHERRIL NELL BABCOCK
*Counsel of Record*

GIANELLI & MORRIS

*Attorneys for Petitioner*
GEORGE PETERSON

**FOR PUBLICATION**

# UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

GEORGE PETERSON,
*Plaintiff-Appellant,*

v.

AMERICAN LIFE & HEALTH INSURANCE COMPANY; CREATIVE HEALTH PROGRAMS; PACIFIC SOUTHWEST ASSOCIATION OF SMALL EMPLOYER FIRMS; RICHARD REYNOLDS,
*Defendants-Appellees.*

No. 93-55973
D.C. No.
CV-91-00160-AHS
OPINION

Appeal from the United States District Court
for the Central District of California
Alicemarie H. Stotler, District Judge, Presiding

Argued and Submitted
December 8, 1994—Pasadena, California

Filed February 15, 1995

Before: Betty B. Fletcher, David R. Thompson,
and Pamela Ann Rymer, Circuit Judges.

Opinion by Judge Fletcher

## COUNSEL

Robert S. Gianelli, Sherril Nell Babcock, Gianelli & Morris, Los Angeles, California, for the plaintiff-appellant.

Joseph D. McNeil, Edward A. Stumpp, McNeil and Susson, Santa Ana, California, for the defendants-appellees.

## OPINION

FLETCHER, Circuit Judge:

George Peterson appeals the district court's grant of summary judgment in favor of the defendants in his suit for benefits under a health insurance policy. We have jurisdiction and affirm.

## I. BACKGROUND

Peterson is a partner in Quivira Marine Service Center ("Quivira"). Quivira applied to American Life and Health

Insurance Co. ("American") for a short-term group policy through the Pacific Southwest Association of Small Employer Firms ("PSA") to provide health insurance for three persons: Peterson, his partner, and their employee. The American policy was intended to provide coverage while Quivira secured a long-term policy with another insurer. Quivira moved coverage for Peterson's partner and the employee to another insurer as intended; Peterson, however, remained on the American policy because he failed a physical examination required by the new insurer.

After Peterson's partner and employee were removed from the American policy, Peterson underwent emergency quintuple coronary bypass surgery. American denied Peterson's claims for expenses associated with the surgery on the basis of an exclusion in the policy stating that no benefits are payable for "[a]ny condition of the tonsils or adenoids, laminectomy, discectomy, spinal fusion, disease or disorder of the reproductive system, gall bladder, rectum, varicose veins, or *conditions requiring bypass surgery*" (emphasis added).

Peterson filed a complaint in California state court against American,[1] alleging various state common law claims. American removed the suit to the district court under the provisions of the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1001, *et seq.*, then moved to dismiss all of Petersons' claims on the ground that ERISA preempted them. In response, Peterson moved to remand the action to state court, alleging that the American policy was not part of an ERISA plan and, therefore, the district court lacked subject matter jurisdiction. The district court determined that ERISA governed the American policy and preempted Peterson's state law claims. Consequently, the court denied Peterson's motion

[1]Other defendants referred to collectively as "American" are PSA; American's parent, Creative Health Programs; and Richard G. Reynolds. Reynolds was dismissed from the suit, and Peterson does not appeal.

to remand and granted American's motion to dismiss, with leave to amend.

Peterson filed a First Amended Complaint pleading a claim for benefits under ERISA. Peterson retained in the amended complaint his state common law claims to preserve them for appeal, and, pursuant to the defendants' motion, the court dismissed the common law causes of action without leave to amend. Peterson also argued that Cal. Ins. Code § 10291.5(b)(7) required American to cover coronary bypass surgery and that this requirement was not preempted by ERISA. The district court granted summary judgment in favor of American, finding that ERISA preempted Peterson's state statutory claim and that the policy's exclusion of bypass surgery was unambiguous and enforceable.

## II. SUBJECT MATTER JURISDICTION OVER AN ERISA PLAN

[1] The district court held that the American policy was part of an "employee welfare benefit plan" as defined in 29 U.S.C. § 1002(1) and that, as a "beneficiary" of the policy, Peterson had standing to bring a civil suit to enforce ERISA. Accordingly, the district court determined that ERISA governed Peterson's claim and that the court had subject matter jurisdiction. We agree.

### A. Existence of an ERISA Plan

An "employee welfare benefit plan" governed by ERISA is:

> any plan, fund, or program which was heretofore or is hereafter established or maintained by an employer or by an employee organization, or by both, to the extent that such plan, fund, or program was established or is maintained for the purpose of providing *for its participants or their beneficiaries,*

> through the purchase of insurance or otherwise, (A) medical, surgical, or hospital care or benefits . . .

29 U.S.C. § 1002(1) (emphasis added).

[2] The regulations implementing this section provide that a plan "under which no employees are participants" does not constitute an ERISA employee benefit plan. 29 C.F.R. § 2510.3-3(b). Neither an owner of a business nor a partner in a partnership can constitute an "employee" for purposes of determining the existence of an ERISA plan. 29 C.F.R. § 2510.3-3(c)(1), (2); *see also Kennedy v. Allied Mut. Ins. Co.*, 952 F.2d 262, 264 (9th Cir. 1991) (ERISA does not govern a plan whose only fully vested beneficiaries are a company's owners).

[3] Peterson maintains that the American policy does not constitute an ERISA employee benefit plan because, at the time of his bypass surgery, it covered only him, a partner in the Quivira partnership. However, the fact that the American policy covered only a Quivira partner at the time of Peterson's surgery is not determinative.[2] We conclude that the American policy was just one component of Quivira's employee benefit program and that the program, taken as a whole, constitutes an ERISA plan.

[4] At all times relevant to this action, Quivira continued to provide insurance to at least one non-partner employee, albeit not under the American policy. *See Kennedy*, 952 F.2d at 264 (coverage of even one non-owner employee is sufficient to

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[2]American argues that our decision in *Harper v. American Chambers Life Ins. Co.*, 898 F.2d 1432 (9th Cir. 1990), supports the position that the American policy is part of an ERISA plan. However, in *Harper*, we refused to decide whether a plan benefitting only a company's partners was an ERISA plan, stating that the case's record was too "scant" to support any position sufficiently. *Id.* at 1433. As explained *infra*, *Harper* simply states that, *if* a plan is governed by ERISA, an employer benefitting from the plan may bring a civil suit to enforce it.

bring a policy within ERISA's scope); *Madonia v. Blue Cross & Blue Shield of Virginia*, 11 F.3d 444, 448 (4th Cir. 1993), *cert. denied*, ___ U.S. ___, 114 S. Ct. 1401 (1994) (coverage of non-owner employees rendered policy an ERISA plan). Quivira not only paid its partners' and employees' insurance premiums but also played an active role in the administration of the coverage, including choosing the insurance, adding and deleting employees and partners from various policies, contacting insurance companies for employees and partners, and distributing information relevant to the coverage.

[5] Moreover, the American policy originally covered a non-partner employee in addition to Peterson and his partner. A policy is governed by ERISA if it is "*established* or maintained by an employer . . . for the purpose of providing [medical insurance] for its participants or their beneficiaries." 29 U.S.C. § 1002(1) (emphasis added). That the American policy is governed by ERISA finds further support in our cases addressing "conversion" policies, where an employee converts his group policy to an individual policy when he leaves his employment. We have held repeatedly that, because these policies are derived from ERISA plans, they continue to be governed by ERISA even after conversion. *Qualls v. Blue Cross of California, Inc.*, 22 F.3d 839, 843 n.4 (9th Cir. 1994); *Greany v. Western Farm Bureau Life Ins. Co.*, 973 F.2d 812, 817 (9th Cir. 1992); *Tingey v. Pixley-Richards West, Inc.*, 953 F.2d 1124, 1132-33 (9th Cir. 1992).

[6] Because the American policy was purchased by Quivira for the purpose of fulfilling its plan to provide benefits to its employees as well as its partners, the policy is part of an ERISA plan and is governed by ERISA.

### B. Standing to Bring an ERISA Claim

Peterson maintains that his claim for benefits nevertheless is governed by state law because, as a partner, he does not have standing to bring an action for benefits under ERISA. A

civil action under ERISA may be brought by "a participant or beneficiary." 29 U.S.C. § 1132(a)(1). A "participant" is "any employee or former employee of an employer." *Id.* § 1002(7). A "beneficiary" is "a person designated by a participant, or by the terms of an employee benefit plan, who is or may become entitled to a benefit thereunder." *Id.* § 1002(8).

[7] This court already has addressed, in *Harper v. American Chambers Life Ins. Co.*, 898 F.2d 1432 (9th Cir. 1990), whether a partner insured by a policy that is part of an ERISA plan has standing to bring a civil suit to enforce ERISA. In *Harper*, we held that a partner could not bring a suit as a "participant" because only employees are participants, but that a partner could enjoy standing as a "beneficiary:"

> First, we note that the broad statutory definition of a "person" for ERISA purposes certainly encompasses [the partners]: "the term 'person' means an individual, partnership, joint venture, corporation, mutual company, joint-stock company, trust, estate, unincorporated organization, association, or employee organization." *See* 29 U.S.C. § 1002(9). Second, [the partners] are "person[s] designated . . . by the terms of an employee benefit plan" if the [insurance] policy is an ERISA plan. 29 U.S.C. § 1002(8). . . . By the plain terms of the statutes defining "person" and "beneficiary," then, [the partners] are ERISA beneficiaries of the [insurance] policy.

898 F.2d at 1434.

Despite Peterson's arguments to the contrary, neither our decision in *Kennedy* nor the Supreme Court's in *Nationwide Mutual Insurance Co. v. Darden*, ___ U.S. ___, 112 S. Ct. 1344 (1992), requires us to depart from our holding in *Harper*. *Kennedy* involved an attempt by two business owners to enforce an insurance policy under ERISA. To determine

whether the policy was part of an ERISA plan, we remanded to the district court to determine whether the policy covered any non-owner employees. 952 F.2d at 267. Necessarily underlying our remand was the assumption that, if other employees were covered, the plan was governed by ERISA and the owners' ERISA suit could proceed. Had we believed that the owners lacked standing to enforce ERISA, even if the policy were part of an ERISA plan, we would have ruled on that basis. Thus, *Kennedy* actually demonstrates *Harper's* continued vitality.

In *Darden*, the Supreme Court clarified the definition of "participant" and held that traditional agency principles govern whether a person is an "employee" within the definition of "participant," 112 S.Ct. at 1348-50; the Court did not address the scope of "beneficiary" standing under ERISA. Although the Court stated as an introduction to its discussion that the plaintiff's suit could survive "only if" he was an employee, *id.* at 1347, we do not interpret this single sentence as undermining *Harper*. The plaintiff in *Darden* did not claim to have standing as a beneficiary, only as a participant, *see Nationwide Mut. Ins. Co. v. Darden*, 796 F.2d 701, 704 n.3 (4th Cir. 1986), *rev'd*, ___ U.S. ___, 112 S. Ct. 1344 (1992); therefore, the issue decided in *Harper* was not considered by either the Fourth Circuit or the Supreme Court.

**[8]** Peterson apparently would have us limit the definition of "beneficiary" to persons such as spouses and dependents, designated by participants to receive benefits. We conclude, though, that any person designated to receive benefits from a policy that is part of an ERISA plan may bring a civil suit to enforce ERISA. To hold otherwise would create the anomaly of requiring some insureds to pursue benefit claims under state law while requiring others covered by the identical policy to proceed under ERISA. Such a scenario would frustrate Congress's intent of achieving uniformity in the law governing employment benefits. More importantly, ERISA's plain language includes as beneficiaries not only those "designated

by a participant," but also those who are designated to receive benefits "*by the terms of an employee benefit plan.*" 29 U.S.C. § 1002(8) (emphasis added). Our interpretation in *Harper* of this clear statutory language is sound and has not been undermined. Peterson has standing to bring a civil suit to enforce ERISA.

## III. STATE LAW CLAIMS

Peterson concedes that ERISA preempts his state common law claims if the American policy is part of an ERISA plan and if he has standing to enforce ERISA. ERISA's preemption clause provides that, "Except as provided in subsection (b) of this section, [ERISA] shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan . . ." 29 U.S.C. § 1144(a). ERISA preemption is "conspicuous for its breadth," *FMC Corp. v. Holliday*, 498 U.S. 52, 58 (1990), and ERISA "contains one of the broadest preemption clauses ever enacted by Congress." *Evans v. Safeco Life Ins. Co.*, 916 F.2d 1437, 1439 (9th Cir. 1990); *accord Aloha Airlines, Inc. v. Ahue*, 12 F.3d 1498, 1501 (9th Cir. 1993); *Greany*, 973 F.2d at 817.

[9] Under ERISA's "savings clause," however, ERISA does not preempt "any law of any State which regulates insurance . . ." 29 U.S.C. § 1144(b)(2)(A). A state law "regulates insurance" and is therefore saved from preemption if it is limited to the insurance industry, has the effect of transferring or spreading a policyholder's risk, and is an integral part of the relationship between the insured and insurer. *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 743 (1985).

[10] ERISA does not preempt state statutes requiring the inclusion of particular types of benefits in insurance policies. The Supreme Court made clear in *Metropolitan* that such "mandated benefit" statutes "regulate insurance" and are saved from preemption. *Id.* at 742-44. Peterson maintains that Cal. Ins. Code § 10291.5(b)(7) and its implementing regula-

tions required American to provide benefits for coronary bypass surgery and that, together, the statute and regulations constitute a "mandated benefit" requirement saved from preemption under *Metropolitan*.

[11] Although we agree that ERISA does not preclude the State of California from requiring insurers to provide coverage for coronary bypass surgery, nothing in the California Insurance Codes mandates such coverage. Cal. Ins. Code § 10291.5(b)(7) provides that California's Insurance Commissioner "shall not approve" any insurance policy if "any benefit of the policy is, or the benefits of the policy as a whole are, not sufficient to be of real economic value to the insured." Peterson maintains that the American policy's exclusion of costs associated with bypass surgery renders it without real economic value. Under regulations promulgated by the Insurance Commissioner, defining "standards for determining conformity" with section 10291.5(b)(7), a policy is presumed to lack real economic value "if it is subject to exceptions" other than those specifically enumerated. 10 Cal. Code Regs. § 2220.8(a). The list of permissible exclusions does not include costs associated with bypass surgery. *Id.* § 2220.8(b).

[12] However, Cal. Ins. Code § 10291.5(b)(7) does not apply to "group disability insurance," Cal. Ins. Code § 10270.95, and the Commissioner's regulations implementing section 10291.5(b)(7) apply only to "individual disability policies." To avoid this exception, Peterson maintains that, despite its label as a "group policy," the American policy is not truly a group policy. To constitute "group disability insurance" under California law, a policy must be issued to an association "formed and continuously maintained in good faith for purposes other than that of obtaining insurance." Cal. Ins. Code § 10270.5(a)(3). Peterson contends that PSA was formed for the sole purpose of providing insurance through American. Therefore, he argues, the American policy is not a "true" group policy and, under 10 Cal. Code Regs. § 2220.8,

should have included bypass surgery coverage or is presumed to lack real economic value.

[13] Peterson's attempt to liken Cal. Ins. Code § 10291.5(b)(7) to a mandated benefit statute falls short. Unlike a mandated benefit statute, Cal. Ins. Code § 10291.5(b)(7) does not require insurers to provide coverage for costs associated with a particular condition or procedure. It simply establishes the parameters within which the Commissioner exercises his discretion to approve or disapprove insurance policies. If the Commissioner approves a policy that does not comply with the requirements of section 10291.5(b)(7), he has the authority to revoke his approval for good cause. 10 Cal. Code Regs. 2196.4 (good cause to revoke approval of policy that is "unfair, unreasonable or otherwise inconsistent with the provisions of the Insurance Code").

The Commissioner also has an obligation to fulfill his duties under the California Insurance Code. Cal. Ins. Code § 12921. If an insured such as Peterson believes that the Commissioner has abused his discretion by approving a policy in violation of either § 10291.5(b)(7) of the Code or the Commissioner's own regulations implementing the Code, then he may petition for a writ of mandamus requiring the Commissioner to revoke his approval. Cal. Code Civ. Proc. § 1094.5; *see generally Bixby v. Pierno*, 93 Cal. Rptr. 234 (Cal. 1971).

[14] However, we do not believe that, in enacting section 10291.5(b)(7), the California legislature intended to permit an insured to reform the nature of his policy and obtain benefits for which he never bargained by engaging courts to second-guess the Commissioner's approval of the policy as providing "group" insurance. Regardless of whether the Insurance Commissioner should have approved the policy,[3] an otherwise

[3]We do not address whether, if characterized as an individual policy, the American policy does in fact lack real economic value under section 10291.5(b)(7). Even with the policy's exclusion for costs associated with

valid policy is a binding contract and governs the obligations of the parties until the Commissioner revokes his approval. Had the California legislature intended otherwise, it would not have provided that a policy approved by the Commissioner, "*as between the insurer and the insured*," is "conclusively presumed to comply with" section 10291.5(b)(7). Cal. Ins. Code § 10291.5(k); *see also Producers Dairy Delivery Co. v. Sentry Ins. Co.*, 226 Cal. Rptr. 558, 565 (Cal. 1986) ("[W]e find persuasive the argument that the commissioner would not likely approve a policy violating one of his own rules."). The American policy, labeled a "group" policy, was approved by the Insurance Commissioner. In light of this approval, we do not see how a statute providing the criteria for such approval enables Peterson to maintain a private action against American to rewrite the terms of his policy.

## IV. INTERPRETATION OF THE AMERICAN POLICY

[15] The district court held that the American policy's exclusion of bypass surgery was unambiguous and enforceable. We agree.

As an initial matter, we dispose of Peterson's argument that we adopt as federal common law a prohibition against exclusions of bypass surgery. Although Congress has authorized us "to formulate a nationally uniform federal common law to supplement the explicit provisions and general policies set out in ERISA," *Menhorn v. Firestone Tire & Rubber Co.*, 738 F.2d 1496, 1500 (9th Cir. 1984), mandating specific types of coverage and defining the scope of such a mandate would

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bypass surgery, the Commissioner could have approved the policy if American "demonstrate[d] to the satisfaction of the Commissioner the need and the reasonable scope of the exception . . . in writing to the Commissioner." 10 Cal. Code Regs. § 2220.9.

exceed the scope of the authority granted because Congress did not regulate the substantive content of welfare benefit plans, *Metropolitan*, 471 U.S. at 732. As we stated in *Blau v. Del Monte Corp.*, 748 F.2d 1348, 1353 (9th Cir. 1984), *cert. denied*, 474 U.S. 865 (1985), "ERISA mandates no minimum substantive content for employee welfare benefit plans, and therefore a court has no authority to draft the substantive content of such plans." *See also Davidowitz v. Delta Dental Plan of California, Inc.*, 946 F.2d 1476, 1480-81 (9th Cir. 1991) (refusing to prohibit non-assignment clauses in welfare benefit plans under federal common law). To do so would go beyond "filling an interstitial 'gap' in ERISA," *DeVoll v. Burdick Painting, Inc.*, 35 F.3d 408, 412 (9th Cir. 1994), and would run counter to the Supreme Court's interpretation: "The authority of courts to develop a 'federal common law' under ERISA is not the authority to revise the text of the statute." *Mertens v. Hewitt Assocs.*, ___ U.S. ___, 113 S. Ct. 2063, 2070 (1993) (citations omitted).

Peterson argues that, even under existing federal law, the exclusion of bypass surgery in the American policy is ambiguous and therefore unenforceable. He maintains that the exclusion of "bypass surgery" does not necessarily exclude coronary bypass surgery because the term's context in the policy suggests that it excludes only *unnecessary* bypass surgeries, such as those used to treat morbid obesity. In Peterson's view, if American intended to exclude treatment of heart disease, one of the nation's biggest killers, it should have highlighted the exclusion prominently rather than place it at the end of a paragraph including procedures that are frequently unnecessary.

Peterson maintains that the exclusion is unenforceable under the doctrines of "*contra proferentem*" and "reasonable expectations." Under the doctrine of *contra proferentem*, we construe ambiguous language in an insurance contract against the insurer. *See Kunin v. Benefit Trust Life Ins. Co.*, 910 F.2d 534, 538-39 (9th Cir.), *cert. denied*, 498 U.S. 1013 (1990).

Under the "reasonable expectations" doctrine, as a matter of federal common law governing ERISA contracts, even an unambiguous exclusion may be unenforceable unless it is sufficiently "clear, plain, and conspicuous" to overcome a layperson's reasonable expectations. *Saltarelli v. Bob Baker Group Medical Trust*, 35 F.3d 382, 385-86 (9th Cir. 1994).

[16] Peterson's reliance on *Saltarelli* and *Kunin* is misplaced. The doctrines enunciated in those cases apply only when a provision in an insurance policy is either ambiguous or not sufficiently conspicuous. We have no doubt that the term "bypass surgery" encompasses coronary bypass surgery; it stretches the imagination to suggest that a reasonable person would understand the term to include only gastric bypass to control morbid obesity. Moreover, the exclusion of bypass surgery not only was included in the policy, but also was highlighted as one of only four exclusions in a "Statement of Understanding" signed by Peterson. The exclusion was unambiguous and conspicuous.

## V. CONCLUSION

The American policy was part of an ERISA plan and Peterson had standing to bring a civil suit to enforce ERISA as a beneficiary of the policy. His state common law claims are preempted, and he has no claim under state statutory law. The exclusion under which American denied benefits for Peterson's coronary bypass surgery was unambiguous, conspicuous and enforceable. We affirm the district court's grant of summary judgment.

AFFIRMED.

UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

**FILED**
APR -6 1995
Cathy A. Catterson, Clerk
U.S. Court of Appeals

GEORGE PETERSON,
Plaintiff-Appellant,
v.
AMERICAN LIFE & HEALTH INSURANCE COMPANY, CREATIVE HEALTH PROGRAMS, PACIFIC SOUTHWEST ASSOCIATION OF SMALL EMPLOYER FIRMS, RICHARD REYNOLDS,
Defendant-Appellees

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No. 93-55973
D.C. No. 91-CV-160

**ORDER**

Before: FLETCHER, THOMPSON, and RYMER,
Circuit Judges

The panel as constituted in the above case has voted to deny the petition for rehearing and to reject the suggestion for rehearing en banc.

The full court has been advised of the suggestion for rehearing en banc and no judge of the court has requested a vote on it. Fed. R. App. P. 35(b).

The petition for rehearing is denied and the suggestion for rehearing en banc is rejected.

UNITED STATES DISTRICT COURT
CENTRAL DISTRICT OF CALIFORNIA

**FILED**
MAY 14, 1993
Clerk, U.S. District Court
Central District of California
Santa Ana Office
/s/

THIS CONSTITUTES NOTICE OF ENTRY
AS REQUIRED BY FRCP, RULE 77(d).

GEORGE PETERSON,
Plaintiff,
v.
AMERICAN LIFE & HEALTH
INSURANCE CO., et al.,
Defendants.

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SA CV 91-160 AHS (RWRx)

**ORDER GRANTING SUMMARY JUDGMENT**

## I.

## INTRODUCTION

On April 22, 1993, the Court issued a minute order electing to treat the present case as one amenable to summary adjudication under the provisions of Rule 56 and under the authority of *Portsmouth Square v. Shareholders Protective Comm.*, 770 F.2d 866 (9th Cir. 1985) because although the case was prepared for trial, it appeared that no factual disputes existed and only legal issues remained to be resolved. On May 3, 1993, defendants submitted a Supplemental Memorandum in

Support of Summary Judgment. Plaintiff filed his Supplemental Memorandum at the Los Angeles Clerk's Office on May 10, 1993 despite the Court's direct order (due to the shortened briefing schedule) to file any supplemental papers in the Santa Ana Clerk's Office; as a result, the Court did not receive plaintiff's Supplemental Memorandum until May 11, 1993. The matter was set for hearing on the Court's May 14, 1993 calendar.

The Court, having received, read and considered the foregoing — as well as each party's proposed Findings of Fact and Conclusions of Law, the counter-marked versions thereof (in conformity with this Court's Standard Order for Court Trials), plaintiff's Trial Brief filed April 13, 1993, defendant's Trial Brief filed the same day, defendants' Motion in Limine to Exclude Evidence re Formation and Maintenance of Pacific Southwest Association of Small Employer Firms filed April 13, 1993, and the Pre-Trial Conference Order filed February 22, 1993 — finds the matter appropriate for submission on the papers without oral argument. *See* Local Rule 7.11 (the Court may dispense with oral argument on any matter unless otherwise required); Fed. R. Civ. P. 78. The matter is, therefore, removed from the Court's May 14, 1993 calendar.

## II.

## ANALYSIS

A court may grant summary judgment if "the pleadings, deposition, answers to interrogatories, and admissions on file, together with the affidavits, if any, show that there is no genuine issue as to any material fact and that the moving party is entitled to a judgment as a matter of law." Fed. R. Civ. P. 56(c). If the party bearing the burden of proof cannot show that the record

raises a genuine issue of fact by providing admissible evidence to the court, summary judgment should be granted. The adverse party to a summary judgment motion may not rest upon mere allegations or denials in his pleadings. *Celotex Corp. v. Catrett*, 477 U.S. 317 (1986). Rather, the party must present *admissible evidence* showing that there is a genuine issue for trial. Fed. R. Civ. P. 56(e). Mere conclusory statements, as they are not admissible evidence, will not survive summary judgment. *Lujan v. National Wildlife Federation*, 497 U.S. 871 (1990); *S.A. Impressa de Viacao Area, Rio Grandense v. Walter Kidde & Co.*, 690 F.2d 1235 (9th Cir. 1980).

In the present case the pertinent facts are undisputed. Despite plaintiff's persistent arguments (which have been previously considered and rejected), the Court has previously determined that the California statute and regulation cited by plaintiff are preempted by ERISA, stricken the causes of action pertaining to the Pacific Southwest Association of Small Employer Firms, concluded that the insurance policy, at issue in a group policy rather than an individual policy, and ruled that any discovery related to these issues was irrelevant to the case. *See, e.g.*, Minute Order dated April 22, 1993. The sole remaining issue of law is whether the term "bypass surgery" in the insurance policy issued by defendant excludes coverage for plaintiff's coronary bypass surgery.

Courts "interpret terms in ERISA insurance policies 'in an ordinary and popular sense as would a [person] of average intelligence and experience.' " *Evans Safeco Life Ins. Co.*, 916 F.2d 1437, 1441 (citing *Allstate Ins. Co. v. Ellison*, 757 F.2d 1042 (9th Cir. 1985)). Moreover, courts "will not artificially create ambiguity where none exists." *Id.* The Court finds, as a matter of law, that the normal and ordinary meaning of the term bypass

surgery includes coronary bypass surgery. The term is not ambiguous, and the Court therefore is not bound by the analysis regarding ambiguous terms undertaken by the Ninth Circuit in *Kunin v. Benefit Trust Life Ins. Co.*, 910 F.2d 534 (9th Cir. 1990). Accordingly, plaintiff's surgery unambiguously falls within the exclusion, and defendants are entitled to judgment as a matter of law.

## III.

## CONCLUSION

For the foregoing reasons, the Court grants summary judgment in favor of defendants. Further, the Court has this date modified, signed and filed defendants, Proposed "Findings of Fact and Conclusions of Law," deemed by the Court to be a Statement of Uncontroverted Facts and Conclusions of Law.

IT IS SO ORDERED.

IT IS FURTHER ORDERED that the Clerk shall serve a copy of this Order on all counsel of record.

Dated: May 14, 1993.

/s/ Alicemarie H. Stotler
Alicemarie H. Stotler
United States District Judge

ter
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UNITED STATES DISTRICT COURT
CENTRAL DISTRICT OF CALIFORNIA

THE HONORABLE ALICEMARIE H. STOTLER,
JUDGE PRESIDING

TENTATIVE RULING* ON LAW
& MOTION MATTERS

October 7, 1991 Calendar No. 4

CASE: GEORGE PETERSON V. AMERICAN LIFE
& HEALTH INS. CO., et al.
SA CV 91-160 AHS (RWRx)

MOTION(S) PENDING:

1. PLAINTIFF'S MOTION TO REMAND
2. DEFENDANTS' MOTION TO DISMISS
OR STRIKE

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1. The Court denies plaintiff's motion to remand. Suits brought to enforce rights under an employee welfare benefit plan, even if they allege only state law claims, are preempted by ERISA and so are removable. 29 U.S.C. § 1144(a); *Metropolitan Life Insurance Company v. Taylor*, 481 U.S. 58, 107 S.Ct. 1542, 95

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* If all counsel submit for ruling on this Tentative Ruling and notify the Courtroom Deputy Clerk immediately, this Tentative Ruling will become the Court's minute order. After all appearances and submissions have been noted by the Clerk, the matter will not be called and there will be no need to remain. The prevailing party shall prepare, serve, and lodge a Proposed Order consistent with this Court's ruling. *See* Local Rule 14.1.

L.Ed.2d 55 (1987); *Pilot Life Insurance Company v. Dedeaux*, 481 U.S. 41, 107 S.Ct., 1549, 95 L.Ed.2d 39 (1987).

The American Life & Health Insurance Co. plan that covered plaintiff during the time at issue in this case was an 1002(1). Plaintiff's company, Quivira Marine Service Center ("Quivira"), paid the premiums for this insurance and performed various administrative duties to maintain it. *See Kanne v. Connecticut General Life Ins. Co.*, 867 F.2d 489, 491-92 (9th Cir. 1988); *Donovan v. Dillingham*, 688 F.2d 1367, 1373 (11th Cir. 1982). Plaintiff's objections to the Penhall Declarations are overruled and the Motion to Strike is denied.

Further, even though plaintiff was a partner in Quivira, his claims are still preempted by ERISA because he was a "beneficiary" of the ERISA plan, within the meaning of 29 U.S.C. § 1002(8). *Harper v. American Chambers Life Ins. Co.*, 898 F.2d 1432, 1434 and n.1 (9th Cir. 1990). The Court notes plaintiff's request that First and Tenth Circuit law and Nevada state case law should control in the Ninth Circuit when there is already a Ninth Circuit case on point, but declines to honor that request. Further, because partners are "beneficiaries," 29 C.F.R. 2510.3-3(c)(2), stating that partners are not "employees," does not apply.

As such, the Court denies plaintiff's Motion for Remand and retains jurisdiction.

2. The Court grants defendants' Motion to Dismiss the complaint on the ground that ERISA preempts plaintiff's claims. *Pilot Life Insurance Company v. Dedeaux*, 481 U.S. 41, 107 S.Ct. 1549, 95 L.Ed.2d 39 (1987); *Metropolitan Life Insurance Company v. Taylor*, 481 U.S. 58, 107 S.Ct. 1542, 95 L.Ed.2d 55 (1987). The Court grants defendants' Motion to Strike plaintiff's claims for punitive damages and for relief based on emotional distress.

a. Plaintiff is granted 20 days to amend his complaint to allege an ERISA claim. *See Harper v. American Chambers Life Ins. Co.*, 898 F.2d 1432, 1435 (9th Cir. 1990).

b. The Court may order stricken from any pleading "any redundant, immaterial, impertinent, or scandalous matter." Fed.R.Civ.P. 12(f). Thus, a motion to strike may be used to strike prayers for relief where damages sought are not recoverable as a matter of law. *Tapley v. Lockwood Green Engineers, Inc.*, 502 F.2d 559 (8th Cir. 1974). 29 U.S.C. § 1132(a) sets the bases for recovery in an ERISA action. *Pilot Life Insurance Co. v. Dedeaux*, 281 U.S. 41, 107 S.Ct. 1549, 1556 (1987); *Massachusetts Mutual v. Russell*, 473 U.S. 134, 105 S.Ct. 3085, 87 L.Ed.2d 96 (1985). Section 1132(a) does not include punitive damages or damages for emotional distress. Therefore, the punitive damages and damages for emotional distress that plaintiff seeks are not recoverable as a matter of law.

3. Defendant is ordered to prepare, serve and lodge proposed Findings of Fact and Conclusions of Law regarding the employee welfare benefit plan at issue and a proposed Order granting Motion to Dismiss.

# APPENDIX E

# TITLE 29. LABOR
## CHAPTER 18. EMPLOYEE RETIREMENT INCOME SECURITY PROGRAM PROTECTION OF EMPLOYEE BENEFIT RIGHTS REGULATORY PROVISIONS
### Administration and Enforcement
### 29 USCS § 1132 (1994)

§ 1132. Civil enforcement

(a) Persons empowered to bring a civil action. A civil action may be brought—

(1) by a participant or beneficiary—

(A) for the relief provided for in subsection (c) of this section, or

(B) to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan;

(2) by the Secretary, or by a participant, beneficiary or fiduciary for appropriate relief under section 409 [29 USCS § 1109]; participant, beneficiary, or fiduciary

(A) to enjoin any act or practice which violates any provision of this title or the terms of the plan, or

(B) to obtain other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of this title or the terms of the plan;

(3) by a participant, beneficiary, or fiduciary

(A) to enjoin any act or practice which violates any provision of this subchapter or the terms of the plan, or

(B) to obtain other appropriate equitable relief (i) to redress such violation or (ii) to enforce any provisions of this subchapter or the terms of the plan;

(4) by the Secretary, or by a participant, or beneficiary for appropriate relief in the case of a violation of 105(c) [29 USCS § 1025(c)];

(5) except as otherwise provided in subsection (b), by the Secretary

(A) to enjoin any act or practice which violates any provision of this title, or

(B) to obtain other appropriate equitable relief (i) to redress such violation or (ii) to enforce any provision of this title;

(6) by the Secretary to collect any civil penalty under subsection (c)(2) or (i) or (l);

(7) by a State to enforce compliance with a qualified medical child support order (as defined in section 609(a)(2)(A) [29 USCS § 1169(a)(2)(A)]);

(8) by the Secretary, or by an employer or other person referred to in section 101(f)(1) [29 USCS § 1021(f)(1)],

(A) to enjoin any act or practice which violates subsection (f) of section 101 [29 USCS § 1021(f)], or

(B) to obtain appropriate equitable relief (i) to redress such violation or (ii) to enforce such subsection; or

(9) in the event that the purchase of an insurance contract or insurance annuity in connection with termination of an individual's status as a participant covered under a pension plan with respect to all or any portion of the participant's pension benefit under such plan constitutes a violation of part 4 of this title or the terms of the plan, by the Secretary, by any individual who was a participant or beneficiary at the time of the alleged violation, or by a fiduciary, to obtain appropriate relief, including the posting of security if necessary, to assure receipt by the participant or beneficiary of the amounts provided or to be provided by such insurance contractor annuity, plus reasonable prejudgment interest on such amounts.

(b) Plans qualified under Internal Revenue Code; maintenance of actions involving delinquent contributions.

(1) In the case of a plan which is qualified under section 401(a), 403(a), or405(a) of the Internal Revenue Code of 1986 (or with respect to which an application to so qualify has been filed and has not been finally determined) the Secretary may exercise his authority under subsection (a)(5) with respect toa violation of, or the enforcement of, parts 2 and 3 of this subtitle [29 USCS § 1051 et seq., § 1081 et seq.] (relating to participation, vesting, and funding), only if—

(A) requested by the Secretary of the Treasury, or

(B) one or more participants, beneficiaries, or fiduciaries, of such plan request in writing (in such manner as the Secretary shall prescribe by regulation) that he exercise such authority on their behalf. In the case of such a request under this paragraph he may exercise such authority only if he determines that such violation affects, or such enforcement is necessary to protect, claims of participants or beneficiaries to benefits under the plan.

(2) The Secretary shall not initiate an action to enforce section 515 [29 USCS § 1145].

(c) Administrator's refusal to supply requested information; penalty for failure to provide annual report in complete form.

(1) Any administrator (A) who fails to meet the requirements of paragraph (1) or (4) of section 606 or section 101(e)(1) [29 USCS § 1166(1) or (4) or § 1021(e)(1)] with respect to a participant or beneficiary, or (B) who fails or refuses to comply with a request for any information which such administrator is required by this title to furnish to a participant or beneficiary (unless such failure or refusal results from matters reasonably beyond the control of the administrator) by mailing the material requested to the last known address of the requesting participant or beneficiary within 30 days after such request may in the court's discretion be personally

liable to such participant or beneficiary in the amount of up to $ 100 a day from the date of such failure or refusal, and the court may in its discretion order such other relief as it deems proper.

(2) The Secretary may assess a civil penalty against any plan administrator of up to $ 1,000 a day from the date of such plan administrator's failure or refusal to file the annual report required to be filed with the Secretary under section 101(b)(4) [29 USCS § 1021(b)(4)]. For purposes of this paragraph, an annual report that has been rejected under section 104(a)(4) [29 USCS § 1024(a)(4)] for failure to provide material information shall not be treated as having been filed with the Secretary.

(3) Any employer maintaining a plan who fails to meet the notice requirement of section 101(d) [29 USCS § 1021(d)] with respect to any participant or beneficiary or who fails to meet the requirements of section 101(e)(2) [29 USCS § 1021(e)(2)] with respect to any person may in the court's discretion be liable to such participant or beneficiary or to such person in the amount of up to $ 100 a day from the date of such failure, and the court may in its discretion order such other relief as it deems proper.

(4) The Secretary may assess a civil penalty of not more than $ 1,000 for each violation by any person of section 101(f)(1) [29 USCS § 1021(f)(1)]. For purposes of this paragraph, each violation described in subparagraph (A) with respect to any single participant, and each violation described in subparagraph (B) with respect to any single participant or beneficiary, shall be treated as a separate violation. The Secretary and the Secretary of Health and Human Services shall maintain such ongoing consultation as may be necessary and appropriate to coordinate enforcement under this subsection with enforcement under section 1144(c)(8) of the Social Security Act [42 USCS § 1320b-14(c)(8)].

(d) Status of employee benefit plan as entity.

(1) An employee benefit plan may sue or be sued under this title as an entity. Service of summons, subpena, or other legal process of a court upon a trustee or an administrator of an employee benefit plan in his capacity as such shall constitute service upon the employee benefit plan. In a case where a plan has not designated in the summary plan description of the plan an individual as agent for the service of legal process, service upon the Secretary shall constitute such service. The Secretary, not later than 15 days after receipt of service under the preceding sentence, shall notify the administrator or any trustee of the plan of receipt of such service.

(2) Any money judgment under this title against an employee benefit plan shall be enforceable only against the plan as an entity and shall not be enforceable against any other person unless liability against such person is established in his individual capacity under this title.

(e) Jurisdiction.

(1) Except for actions under subsection (a)(1)(B) of this section, the district courts of the United States shall have exclusive jurisdiction of civil actions under this title brought by the Secretary or by a participant, beneficiary, fiduciary, or any person referred to in section 101(f)(1) [29 USCS § 1021(f)(1)]. State courts of competent jurisdiction and district courts of the United States shall have concurrent jurisdiction of actions under paragraphs (1)(B) and (7) of subsection (a) of this section.

(2) Where an action under this title is brought in a district court of the United States, it may be brought in the district where the plan is administered, where the breach took place, or where a defendant resides or may be found, and process may be served in any other district where a defendant resides or may be found.

(f) Amount in controversy; citizenship of parties. The district courts of the United States shall have jurisdiction, without respect to the amount in controversy or the citizenship of the parties, to grant the relief provided for in subsection (a) of this section in any action.

(g) Attorney's fees and costs; awards in actions involving delinquent contributions.

(1) In any action under this title (other than an action described in paragraph 2) by a participant, beneficiary, or fiduciary, the court in its discretion may allow a reasonable attorney's fee and costs of action to either party.

(2) In any action under this title by a fiduciary for or on behalf of a plan to enforce section 515 [29 USCS § 1145] in which a judgment in favor of the plan is awarded, the court shall award the plan—

(A) the unpaid contributions,

(B) interest on the unpaid contributions,

(C) an amount equal to the greater of—

(i) interest on the unpaid contributions, or

(ii) liquidated damages provided for under the plan in an amount not in excess of 20 percent (or such higher percentage as may be permitted under Federal or State law) of the amount determined by the court under subparagraph (A),

(D) reasonable attorney's fees and costs of the action, to be paid by the defendant, and

(E) such other legal or equitable relief as the court deems appropriate. For purposes of this paragraph, interest on unpaid contributions shall be determined by using the rate provided under the plan, or, if none, the rate prescribed under section 6621 of the Internal Revenue Code of 1986 [26 USCS § 6621].

(h) Service upon Secretary of Labor and Secretary of the Treasury. A copy of the complaint in any action under this title by a participant, beneficiary, or fiduciary (other than an action brought by one or more participants

or beneficiaries under subsection (a)(1)(B) which is solely for the purpose of recovering benefits due such participants under the terms of the plan) shall be served upon the Secretary and the Secretary of the Treasury by certified mail. Either Secretary shall have the right in his discretion to intervene in any action, except that the Secretary of the Treasury may not intervene in any action under part 4 of this subtitle [29 USCS §§ 1101 et seq.]. If the Secretary brings an action under subsection (a) on behalf of a participant or beneficiary, he shall notify the Secretary of the Treasury.

(i) Administrative assessment of civil penalty. In the case of a transaction prohibited by section 406 [29 USCS § 1106] by a party in interest with respect to a plan to which this part applies, the Secretary may assess a civil penalty against such party in interest. The amount of such penalty may not exceed 5 percent of the amount involved in each such transaction (as defined in section 4975(f)(4) of the Internal Revenue Code of 1986 [26 USCS § 4975(f)(4)]) for each year or part thereof during which the prohibited transaction continues, except that, if the transaction is not corrected (in such manner as the Secretary shall prescribe in regulations which shall be consistent with section 4975(f)(5) of such Code [26 USCS § 4975(f)(5)]) within 90 days after notice from the Secretary (or such longer period as the Secretary may permit), such penalty may be in an amount not more than 100 percent of the amount involved. This subsection shall not apply to a transaction with respect to a plan described in section 4975(e)(1) of such Code [26 USCS § 4975(e)(1)].

(j) Direction and control of litigation by Attorney General. In all civil actions under this title, attorneys appointed by the Secretary may represent the Secretary (except as provided in section 518(a) of title 28, United States Code), but all such litigation shall be subject to the direction and control of the Attorney General.

(k) Jurisdiction of actions against the Secretary of Labor. Suits by an administrator, fiduciary, participant, or beneficiary of an employee benefit plan to review a final order of the Secretary, to restrain the Secretary from taking any action contrary to the provisions of this Act, or to compel him to take action required under this title, may be brought in the district court of the United States for the district where the plan has its principal office, or in the United States District Court for the District of Columbia.

(l) Civil penalties on violations by fiduciaries.

(1) In the case of — (A) any breach of fiduciary responsibility under (or other violation of) part 4 [29 USCS § 1101 et seq.] by a fiduciary, or (B) any knowing participation in such a breach or violation by any other person, the Secretary shall assess a civil penalty against such fiduciary or other person in an amount equal to 20 percent of the applicable recovery amount.

(2) For purposes of paragraph (1), the term "applicable recovery amount" means any amount which is recovered from a fiduciary or other person with respect to a breach or violation described in paragraph (1) — (A) pursuant to any settlement agreement with the Secretary, or (B) ordered by a court to be paid by such fiduciary or other person to a plan or its participants and beneficiaries in a judicial proceeding instituted by the Secretary under subsection (a)(2) or (a)(5).

(3) The Secretary may, in the Secretary's sole discretion, waive or reduce the penalty under paragraph (1) if the Secretary determines in writing that — (A) the fiduciary or other person acted reasonably and in good faith, or (B) it is reasonable to expect that the fiduciary or other person will not be able to restore all losses to the plan (or to provide the relief ordered pursuant to subsection (a)(9)) without severe financial hardship unless such waiver or reduction is granted.

(4) The penalty imposed on a fiduciary or other person under this subsection with respect to any transaction shall be reduced by the amount of any penalty or tax imposed on such fiduciary or other person with respect to such transaction under subsection (i) of this section and section 4975 of the Internal Revenue Code of 1986 [26 USCS § 4975].

(m) In the case of a distribution to a pension plan participant or beneficiary in violation of section 206(e) [29 USCS § 1056(e)] by a plan fiduciary, the Secretary shall assess a penalty against such fiduciary in an amount equal to the value of the distribution. Such penalty shall not exceed $ 10,000 for each such distribution.

HISTORY: (Sept. 2, 1974, P.L. 93-406, Title I, Subtitle B, Part 5, § 502, 88 Stat. 891; Sept. 26, 1980, P.L. 96-364, Title III, § 306(b), 94 Stat. 1295; Apr.7, 1986, P.L. 99-272, Title X, § 10002(b), 100 Stat. 231; Dec. 22, 1987, P.L. 100-203, Title IX, Subtitle D, Part II, Subpart D, § 9342(c), 9344, 101 Stat. 1330-372, 1330-373, Dec. 19, 1989, P.L. 101-239, Title II, Subtitle B, § 2101(a), (b), Title VII, Subtitle G, Part V, Subpart C, § 7881(b)(5)(B), (j)(2),(3), Subpart D, § 7891(a)(1), 7894(f)(1), 103 Stat. 2123, 2438, 2442, 2445, 2450.) (As amended Nov. 5, 1990, P.L. 101-508, Title XII, Subtitle B, § 12021(d)(2),104 Stat. 1388-573; Aug. 10, 1993, P.L. 103-66, Title IV, Subtitle D, § 4301(c)(1)-(3), 107 Stat. 376; Oct. 22, 1994, P.L. 103-401, § 2, 3, 108 Stat. 4172; Dec. 8, 1994, P.L. 103-465, Title VII, Subtitle F, Part I, Subpart B, § 761(a)(9)(B)(ii), 108 Stat. 5033.)

# TITLE 29. LABOR
# CHAPTER 18. EMPLOYEE RETIREMENT INCOME SECURITY PROGRAM
# PROTECTION OF EMPLOYEE BENEFIT RIGHTS GENERAL PROVISIONS
# 29 USCS § 1002 (1994)

§ 1002. Definitions
For purposes of this title:

(1) The terms "employee welfare benefit plan" and "welfare plan" mean any plan, fund, or program which was heretofore or is hereafter established or maintained by an employer or by an employee organization, or by both, to the extent that such plan, fund, or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, (A) medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, death or unemployment, or vacation benefits, apprenticeship or other training programs, or day care centers, scholarship funds, or prepaid legal services, or (B) any benefit described in section 302(c) of the Labor Management Relations Act, 1947 [29 USCS § 186(c)] (other than pensions on retirement or death, and insurance to provide such pensions).
(2)

(A) Except as provided in subparagraph (B), the terms "employee pension benefit plan" and "pension plan" mean any plan, fund, or program which was heretofore or is hereafter established or maintained by an employer or by an employee organization, or by both, to the extent that by its express terms or as a result of surrounding circumstances such plan, fund, or program—

(i) provides retirement income to employees, or

(ii) results in a deferral of income by employees for periods extending to the termination of covered employment or beyond, regardless of the method of calculating the contributions made to the plan, the method of calculating the benefits under the plan or the method of distributing benefits from the plan.

(B) The Secretary may by regulation prescribe rules consistent with the standards and purposes of this Act providing one or more exempt categories under which—

(i) severance pay arrangements, and

(ii) supplemental retirement income payments,

under which the pension benefits of retirees or their beneficiaries are supplemented to take into account some portion or all of the increases in the cost of living (as determined by the Secretary of Labor) since retirement, shall, for purposes of this title, be treated as welfare plans rather than pension plans. In the case of any arrangement or payment a principal effect of which is the evasion of the standards or purposes of this Act applicable to pension plans, such arrangement or payment shall be treated as a pension plan.

(3) The term "employee benefit plan" or "plan" means an employee welfare benefit plan or an employee pension benefit plan or a plan which is both an employee welfare benefit plan and an employee pension benefit plan.

(4) The term "employee organization" means any labor union or any organization of any kind, or any agency or employee representation committee, association, group, or plan, in which employees participate and which exists for the purpose, in whole or in part, of dealing with employers concerning an employee benefit plan, or other matters incidental to employment relationships; or any employees' beneficiary association organized for the purpose in whole or in part, of establishing such a plan.

(5) The term "employer" means any person acting

directly as an employer, or indirectly in the interest of an employer, in relation to an employee benefit plan; and includes a group or association of employers acting for an employer in such capacity.

(6) The term "employee" means any individual employed by an employer.

(7) The term "participant" means any employee or former employee of an employer, or any member or former member of an employee organization, who is or may become eligible to receive a benefit of any type from an employee benefit plan which covers employees of such employer or members of such organization, or whose beneficiaries may be eligible to receive any such benefit.

(8) The term "beneficiary" means a person designated by a participant, or by the terms of an employee benefit plan, who is or may become entitled to a benefit thereunder.

(9) The term "person" means an individual, partnership, joint venture, corporation, mutual company, joint-stock company, trust, estate, unincorporated organization, association, or employee organization.

(10) The term "State" includes any State of the United States, the District of Columbia, Puerto Rico, the Virgin Islands, American Samoa, Guam, Wake Island, and the Canal Zone. The term "United States" when used in the geographic sense means the States and the Outer Continental Shelf lands defined in the Outer Continental Shelf Lands Act (43 U.S.C. §§ 1331-1343).

(11) The term "commerce" means trade, traffic, commerce, transportation, or communication between any State and any place outside thereof.

(12) The term "industry or activity affecting commerce" means any activity, business, or industry in commerce or in which a labor dispute would hinder or obstruct commerce or the free flow of commerce, and includes any activity or industry "affecting commerce" within the

meaning of the Labor Management Relations Act, 1947, or the Railway Labor Act.

(13) The term "Secretary" means the Secretary of Labor.

(14) The term "party in interest" means, as to an employee benefit plan—

(A) any fiduciary (including, but not limited to, any administrator, officer, trustee, or custodian), counsel, or employee of such employee benefit plan;

(B) a person providing services to such plan;

(C) an employer any of whose employees are covered by such plan;

(D) an employee organization any of whose members are covered by such plan;

(E) an owner, direct or indirect, of 50 percent or more of—

(i) the combined voting power of all classes of stock entitled to vote or the total value of shares of all classes of stock of a corporation.

(ii) the capital interest or the profits interest of a partnership, or

(iii) the beneficial interest of a trust or unincor porated enterprise, which is an employer or an employee organization described in subparagraph C) or (D);

(F) a relative (as defined in paragraph (15)) of any individual described in subparagraph (A), (B), (C), or (E);

(G) a corporation, partnership, or trust or estate of which (or in which) 50 percent or more of—

(i) the combined voting power of all classes of stock entitled to vote or the total value of shares of all classes of stock of such corporation,

(ii) the capital interest or profits interest of such partnership, or

(iii) the beneficial interest of such trust or estate, is owned directly or indirectly, or held by persons described in subparagraph (A), (B), (C), (D), or (E);

(H) an employee, officer, director (or an individual having powers or responsibilities similar to those of officers or directors), or a 10 percent or more shareholder directly or indirectly, of a person described in subparagraph (B), (C), (D), (E), or (G), or of the employee benefit plan; or

(I) a 10 percent or more (directly or indirectly in capital or profits) partner or joint venturer of a person described in subparagraph (B), (C), (D), (E), or (G).

The Secretary, after consultation and coordination with the Secretary of the Treasury, may by regulation prescribe a percentage lower than 50 percent for subparagraph (E) and (G) and lower than 10 percent for subparagraph (H) or (I). The Secretary may prescribe regulations for determining the ownership (direct or indirect) of profits and beneficial interests, and the manner in which indirect stockholdings are taken into account. Any person who is a party in interest with respect to a plan to which a trust described in section 501(c)(22) of the Internal Revenue Code of 1986 [26 USCS § 501(c)(22)] is permitted to make payments under section 4223 [29 USCS § 1403] shall be treated as a party in interest with respect to such trust.

(15) The term "relative" means a spouse, ancestor, lineal descendant, or spouse of a lineal descendant.

(16) (A) The term "administrator" means—

(i) the person specifically so designated by the terms of the instrument under which the plan is operated;

(ii) if an administrator is not so designated, the plan sponsor; or

(iii) in the case of a plan for which an administrator is not designated and a plan sponsor cannot be identified, such other person as the Secretary may by regulation prescribe.

(B) The term "plan sponsor" means

(i) the employer in the case of an employee-benefit plan established or maintained by a single employer,

(ii) the employee organization in the case of a plan established or maintained by an employee organization, or

(iii) in the case of a plan established or maintained by two or more employers or jointly by one or more employers and one or more employee organizations, the association, committee, joint board of trustees, or other similar group of representatives of the parties who establish or maintain the plan.

(17) The term "separate account" means an account established or maintained by an insurance company under which income, gains, and losses, whether or not realized, from assets allocated to such account, are, in accordance with the applicable contract, credited to or charged against such account without regard to other income, gains, or losses of the insurance company.

(18) The term "adequate consideration" when used in part 4 of subtitle B [29 USCS §§ 1101 et seq.] means

(A) in the case of a security for which there is a generally recognized market, either

(i) the price of the security prevailing on a national securities exchange which is registered under section 6 of the Securities Exchange Act of 1934 [15 USCS § 78f], or

(ii) if the security is not traded on such a national securities exchange, a price not less favorable to the plan than the offering price for the security as established by the current bid and asked prices quoted by persons independent of the issuer and of any party in interest; and

(B) in the case of an asset other than a security for which there is a generally recognized market, the fair market value of the asset as determined in good faith by the trustee or named fiduciary pursuant to the terms of

the plan and in accordance with regulations promulgated by the Secretary.

(19) The term "nonforfeitable" when used with respect to a pension benefit or right means a claim obtained by a participant or his beneficiary to that part of an immediate or deferred benefit under a pension plan which arises from the participant's service, which is unconditional, and which is legally enforceable against the plan. For purposes of this paragraph, a right to an accrued benefit derived from employer contributions shall not be treated as forfeitable merely because the plan contains a provision described in section 203(a)(3) [29 USCS § 1053(a)(3)].

(20) The term "security" has the same meaning as such term has under section 2(1) of the Securities Act of 1933 (15 U.S.C. 77b(1)).

(21) (A) Except as otherwise provided in subparagraph (B), a person is a fiduciary with respect to a plan to the extent

(i) he exercises any discretionary authority or discretionary control respecting management of such plan or exercises any authority or control respecting management or disposition of its assets,

(ii) he renders investment advice for a fee or other compensation, direct or indirect, with respect to any moneys or other property of such plan, or has any authority or responsibility to do so, or

(iii) he has any discretionary authority or discretionary responsibility in the administration of such plan. Such term includes any person designated under section 405(c)(1)(B) [29 USCS § 1105(c)(1)(B)].

(B) If any money or other property of an employee benefit plan is invested insecurities issued by an investment company registered under the Investment Company Act of 1940, such investment shall not by itself cause such investment company or such investment company's investment adviser or principal underwriter to be deemed

to be a fiduciary or a party in interest as those terms are defined in this title, except insofar as such investment company or its investment adviser or principal underwriter acts in connection with an employee benefit plan covering employees of the investment company, the investment adviser, or its principal underwriter. Nothing contained in this subparagraph shall limit the duties imposed on such investment company, investment adviser, or principal underwriter by any other law.

(22) The term "normal retirement benefit" means the greater of the early retirement benefit under the plan, or the benefit under the plan commencing at normal retirement age. The normal retirement benefit shall be determined without regard to—

(A) medical benefits, and

(B) disability benefits not in excess of the qualified disability benefit. For purposes of this paragraph, a qualified disability benefit is a disability benefit provided by a plan which does not exceed the benefit which would be provided for the participant if he separated from the service at normal retirement age. For purposes of this paragraph, the early retirement benefit under a plan shall be determined without regard to any benefit under the plan which the Secretary of the Treasury finds to be a benefit described in section 204(b)(1)(G) [29 USCS § 1054(b)(1)(G)].

(23) The term "accrued benefit" means—

(A) in the case of a defined benefit plan, the individual's accrued benefit determined under the plan and, except as provided in section 204(c)(3) [29 USCS § 1054(c)(3)], expressed in the form of an annual benefit commencing at normal retirement age, or

(B) in the case of a plan which is an individual account plan, the balance of the individual's account. The accrued benefit of an employee shall not be less than the amount determined under section 204(c)(2)(B) [29 USCS § 1054(c)(2)(B)] with respect to the

employee's accumulated contribution.

(24) The term "normal retirement age" means the earlier of—

(A) the time a plan participant attains normal retirement age under the plan, or

(B) the later of—

(i) the time a plan participant attains age 65, or

(ii) the 5th anniversary of the time a plan participant commenced participation in the plan.

(25) The term "vested liabilities" means the present value of the immediate or deferred benefits available at normal retirement age for participants and their beneficiaries which are nonforfeitable.

(26) The term "current value" means fair market value where available and otherwise the fair value as determined in good faith by a trustee or a named fiduciary (as defined in section 402(a)(2) [29 USCS § 1102(a)(2)]) pursuant to the terms of the plan and in accordance with regulations of the Secretary, assuming an orderly liquidation at the time of such determination.

(27) The term "present value," with respect to a liability, means the value adjusted to reflect anticipated events. Such adjustments shall conform to such regulations as the Secretary of the Treasury may prescribe.

(28) The term "normal service cost" or "normal cost" means the annual cost of future pension benefits and administrative expenses assigned, under an actuarial cost method, to years subsequent to a particular valuation date of a pension plan. The Secretary of the Treasury may prescribe regulations to carry out this paragraph.

(29) The term "accrued liability" means the excess of the present value, as of a particular valuation date of a pension plan, of the projected future benefit costs and administrative expenses for all plan participants and beneficiaries over the present value of future contributions for the normal cost of all applicable plan

participants and beneficiaries. The Secretary of the Treasury may prescribe regulations to carry out this paragraph.

(30) The term "unfunded accrued liability" means the excess of the accrued liability, under an actuarial cost method which so provides, over the present value of the assets of a pension plan. The Secretary of the Treasury may prescribe regulations to carry out this paragraph.

(31) The term "advance funding actuarial cost method" or "actuarial cost method" means a recognized actuarial technique utilized for establishing the amount and incidence of the annual actuarial cost of pension plan benefits and expenses. Acceptable actuarial cost methods shall include the accrued benefit cost method (unit credit method), the entry age normal cost method, the individual level premium cost method, the aggregate cost method, the attained age normal cost method, and the frozen initial liability cost method. The terminal funding cost method and the current funding (pay-as-you-go) cost method are not acceptable actuarial cost methods. The Secretary of the Treasury shall issue regulations to further define acceptable actuarial cost methods.

(32) The term "governmental plan" means a plan established or maintained for its employees by the Government of the United States, by the government of any State or political subdivision thereof, or by any agency or instrumentality of any of the foregoing. The term "governmental plan" also includes any plan to which the Railroad Retirement Act of 1935 or 1937 applies, and which is financed by contributions required under that Act and any plan of an international organization which is exempt from taxation under the provisions of the International Organizations Immunities Act (59 Stat. 669).

(33)

(A) The term "church plan" means a plan established and maintained (to the extent required in clause

(ii) of subparagraph (B)) for its employees (or their beneficiaries) by a church or by a convention or association of churches which is exempt from tax under section 501 of the Internal Revenue Code of 1986 [26 USCS § 501].

(B) The term "church plan" does not include a plan—

(i) which is established and maintained primarily for the benefit of employees (or their beneficiaries) of such church or convention or association of churches who are employed in connection with one or more unrelated trades or businesses (within the meaning of section 513 of the Internal Revenue Code of 1986 [26 USCS § 513]), or

(ii) if less than substantially all of the individuals included in the plan are individuals described in subparagraph (A) or in clause (ii) of subparagraph (C) (or their beneficiaries).

(C) For purposes of this paragraph—

(i) A plan established and maintained for its employees (or their beneficiaries) by a church or by a convention or association of churches includes a plan maintained by an organization, whether a civil law corporation or otherwise, the principal purpose or function of which is the administration or funding of a plan or program for the provision of retirement benefits or welfare benefits, or both, for the employees of a church or a convention or association of churches, if such organization is controlled by or associated with a church or a convention or association of churches.

(ii) The term employee of a church or a convention or association of churches includes—

(I) a duly ordained, commissioned, or licensed minister of a church in the exercise of his ministry, regardless of the source of his compensation;

(II) an employee of an organization, whether a civil law corporation or otherwise, which is

exempt from tax under section 501 of the Internal Revenue Code of 1986 [26 USCS § 501] and which is controlled by or associated with a church or a convention or association of churches; and

(III) an individual described in clause (v).

(iii) A church or a convention or association of churches which is exempt from tax under section 501 of the Internal Revenue Code of 1986 [26 USCS§ 501] shall be deemed the employer of any individual included as an employee under clause (ii).

(iv) An organization, whether a civil law corporation or otherwise, is associated with a church or a convention or association of churches if it shares common religious bonds and convictions with that church or convention or association of churches.

(v) If an employee who is included in a church plan separates from the service of a church or a convention or association of churches or an organization, whether a civil law corporation or otherwise, which is exempt from tax under section 501 of the Internal Revenue Code of 1986 [26 USCS § 501] and which is controlled by or associated with a church or a convention or association of churches, the church plan shall not fail to meet the requirements of this paragraph merely because the plan—

(I) retains the employee's accrued benefit or account for the payment of benefits to the employee or his beneficiaries pursuant to the terms of the plan; or

(II) receives contributions on the employee's behalf after the employee's separation from such service, but only for a period of 5 years after such separation, unless the employee is disabled (within the meaning of the disability provisions of the church plan or, if there are no such provisions in the church plan, within the meaning of section 72(m)(7) of the Internal Revenue Code of 1986 [26 USCS § 72(m)(7)] at the time of such separation from service.

(D)

(i) If a plan established and maintained for its employees (or their beneficiaries) by a church or by a convention or association of churches which is exempt from tax under section 501 of the Internal Revenue Code of 1986 [26 USCS § 501] fails to meet one or more of the requirements of this paragraph and corrects its failure to meet such requirements within the correction period, the plan shall be deemed to meet the requirements of this paragraph for the year in which the correction was made and for all prior years.

(ii) If a correction is not made within the correction period, the plan shall be deemed not to meet the requirements of this paragraph beginning with the date on which the earliest failure to meet one or more of such requirements occurred.

(iii) For purposes of this subparagraph, the term "correction period" means—

(I) the period ending 270 days after the date of mailing by the Secretary of the Treasury of a notice of default with respect to the plan's failure to meet one or more of the requirements of this paragraph; or

(II) any period set by a court of competent jurisdiction after a final determination that the plan fails to meet such requirements, or, if the court does not specify such period, any reasonable period determined by the Secretary of the Treasury on the basis of all the facts and circumstances, but in any event not less than 270 days after the determination has become final; or

(III) any additional period which the Secretary of the Treasury determines is reasonable or necessary for the correction of the default, whichever has the latest ending date.

(34) The term "individual account plan" or "defined contribution plan" means a pension plan which provides for an individual account for each participant and for

benefits based solely upon the amount contributed to the participant's account, and any income, expenses, gains and losses, and any forfeitures of accounts of other participants which may be allocated to such participant's account.

(35) The term "defined benefit plan" means a pension plan other than an individual account plan; except that a pension plan which is not an individual account plan and which provides a benefit derived from employer contributions which is based partly on the balance of the separate account of a participant—

(A) for the purposes of section 202 [29 USCS § 1052], shall be treated as an individual account plan, and the purposes of paragraph (23) of this section and section 204 [29 USCS § 1054], shall be treated as an individual account plan to the extent benefits are based upon the separate account of a participant and as a defined benefit plan with respect to the remaining portion of benefits under the plan.

(36) The term "excess benefit plan" means a plan maintained by an employer solely for the purpose of providing benefits for certain employees in excess of the limitations on contributions and benefits imposed by section 415 of the Internal Revenue Code of 1986 [26 USCS § 415] on plans to which that section applies, without regard to whether the plan is funded. To the extent that a separable part of a plan (as determined by the Secretary of Labor) maintained by an employer is maintained for such purpose, that part shall be treated as a separate plan which is an excess benefit plan.

(37)

(A) The term "multiemployer plan" means a plan—

(i) to which more than one employer is required to contribute,

(ii) which is maintained pursuant to one or more collective bargaining agreements between one or

more employee organizations and more than one employer, and

(iii) which satisfies such other requirements as the Secretary may prescribe by regulation.

(B) For purposes of this paragraph, all trades or businesses (whether or not incorporated) which are under common control within the meaning of section 4001(b)(1) [29 USCS § 1301(b)(1)] are considered a single employer.

(C) Notwithstanding subparagraph (A), a plan is a multiemployer plan on and after its termination date if the plan was a multiemployer plan under this paragraph for the plan year preceding its termination date.

(D) For purposes of this title, notwithstanding the preceding provisions of this paragraph, for any plan year which began before the date of the enactment of the Multiemployer Pension Plan Amendments Act of 1980 [enacted Sept. 26, 1980], the term "multiemployer plan" means a plan described in section 3(37) of this Act [para. (37) of this section] as in effect immediately before such date.

(E) Within one year after the date of the enactment of the Multiemployer Pension Plan Amendments Act of 1980 [enacted Sept. 26, 1980], a multiemployer plan may irrevocably elect, pursuant to procedures established by the corporation and subject to the provisions of sections 4403 [4303](b) and (c) [29 USCS § 1453(b) and (c)], that the plan shall not be treated as a multiemployer plan for all purposes under this Act or the Internal Revenue Code of 1954 [26 USCS § 1 et seq.] if for each of the last 3 plan years ending prior to the effective date of the Multiemployer Pension Plan Amendments Act of 1980—

(i) the plan was not a multiemployer plan because the plan was not a plan described in section 3(37)(A)(iii) of this Act [para. (37)(A)(iii) of this section] and section 414(f)(1)(C) of the Internal Revenue

Code of 1954 [26 USCS § 414(f)(1)(C)] (as such provisions were in effect on the day before the date of the enactment of the Multiemployer Pension Plan Amendments Act of 1980 [enacted Sept. 26, 1980]); and

(ii) the plan had been identified as a plan that was not a multiemployer plan in substantially all its filings with the corporation, the Secretary of Labor and the Secretary of the Treasury.

(F)

(i) For purposes of this title a qualified football coaches plan—

(I) shall be treated as a multiemployer plan to the extent not inconsistent with the purposes of this subparagraph; and

(II) notwithstanding section 401(k)(4)(B) of the Internal Revenue Code of 1986 [26 USCS § 401(k)(4)(B)], may include a qualified cash and deferred arrangement.

(ii) For purposes of this subparagraph, the term "qualified football coaches plan" means any defined contribution plan which is established and maintained by an organization—

(I) which is described in section 501(c) of such Code [26 USCS § 501(c)];

(II) the membership of which consists entirely of individuals who primarily coach football as full-time employees of 4-year colleges or universities described in section 170(b)(1)(A)(ii) of such Code [26 USCS § 170(b)(1)(A)(ii)]; and

(III) which was in existence on September 18, 1986.

(38) The term "investment manager" means any fiduciary (other than a trustee or named fiduciary, as defined in section 402(a)(2) [29 USCS § 1102(a)(2)])—

(A) who has the power to manage, acquire, or dispose of any asset of a plan;

(B) who is

(i) registered as an investment adviser under the Investment Advisers Act of 1940 [<=32> 15 USCS §§ 80b-1 et seq.]; (ii) is a bank, as defined in that Act [15 USCS §§ 80b-1 et seq.]; or

(iii) is an insurance company qualified to perform services described in subparagraph (A) under the laws of more than one State; and

(C) has acknowledged in writing that he is a fiduciary with respect to the plan.

(39) The terms "plan year" and "fiscal year of the plan" mean, with respect to a plan, the calendar, policy, or fiscal year on which the records of the plan are kept.

(40)

(A) The term "multiple employer welfare arrangement" means an employee welfare benefit plan, or any other arrangement (other than an employee welfare benefit plan), which is established or maintained for the purpose of offering or providing any benefit described in paragraph (1) to the employees of two or more employers (including one or more self-employed individuals), or to their beneficiaries, except that such term does not include any such plan or other arrangement which is established or maintained—

(i) under or pursuant to one or more agreements which the Secretary finds to be collective bargaining agreements,

(ii) by a rural electric cooperative, or

(iii) by a rural telephone cooperative association.

(B) For purposes of this paragraph—

(i) two or more trades or businesses, whether or not incorporated, shall be deemed a single employer if such trades or businesses are within the same control group,

(ii) the term "control group" means a group of trades or businesses under common control,

(iii) the determination of whether a trade or business is under "common control" with another trade or business shall be determined under regulations of the Secretary applying principles similar to the principles applied in determining whether employees of two or more trades or businesses are treated as employed by a single employer under section 4001(b) [29 USCS § 1301(b)], except that, for purposes of this paragraph, common control shall not be based on an interest of less than 25 percent,

(iv) the term "rural electric cooperative" means—

(I) any organization which is exempt from tax under section 501(a) of the Internal Revenue Code of 1986 [26 USCS § 501(a)] and which is engaged primarily in providing electric service on a mutual or cooperative basis, and

(II) any organization described in paragraph (4) or (6) of section 501(c) of the Internal Revenue Code of 1986 [26 USCS § 501(c)(4) or (6)] which is exempt from tax under section 501(a) of such Code [26 USCS § 501(a)] and at least 80 percent of the members of which are organizations described in subclause (I), and

(v) the term "rural telephone cooperative association" means an organization described in paragraph (4) or (6) of section 501(c) of the Internal Revenue Code of 1986 [26 USCS § 501(c)(4) or (6)] which is exempt from tax under section 501(a) of such Code [26 USCS § 501(a)] and at least 80 percent of the members of which are organizations engaged primarily in providing telephone service to rural areas of the United States on a mutual, cooperative, or other basis.

(41) Single-employer plan. The term "single-employer plan" means an employee benefit plan other than a multiemployer plan.

(42) The term "single-employer plan" means a plan which is not a multiemployer plan.

HISTORY: (Sept. 2, 1974, P.L. 93-406, Title I, Subtitle A, § 3, 88 Stat. 833; Sept. 26, 1980, P.L. 96-364, Title III, § 302, 305, Title IV, § 407(a), 409, 94 Stat. 1291, 1294, 1303, 1307; Jan. 14, 1983, P.L. 97-473, Title III, § 302(a), 96 Stat. 2612; Apr. 7, 1986, P.L. 99-272, Title XI, § 11016(c)(1), 100 Stat. 273; Oct. 21, 1986, P.L. 99-509, Title IX, Subtitle C, § 9203(b)(1), 100 Stat. 1979; Oct. 22, 1986, P.L. 99-514, Title XVIII, Subtitle A, Ch 7, § 1879(u)(3), 100 Stat. 2913; Dec. 22, 1987, P.L. 100-202, § 136(a), 101 Stat. 1329-441; Dec. 19, 1989, P.L. 101-239, Title VII, Subtitle G, Part V, Subpart B, § 7871(b)(2), Subpart C, § 7881(m)(2)(D), Subpart D, § 7891(a)(1), 7893(a), 7894(a)(1)(A), (2)(A), (3), (4), 103 Stat. 2435, 2444, 2445, 2447, 2448.) (As amended Nov. 5, 1990, P.L. 101-508, Title XII, Subtitle A, § 12002(b)(2)(C), 104 Stat. 1388-566; Aug. 14, 1991, P.L. 102-89, § 2, 105 Stat. 446.)

# APPENDIX G

# TITLE 29. LABOR
## CHAPTER 18. EMPLOYEE RETIREMENT INCOME SECURITY PROGRAM PROTECTION OF EMPLOYEE BENEFIT RIGHTS REGULATORY PROVISIONS
### Fiduciary Responsibility
### 29 USCS § 1103 (1994)

§ 1103. Establishment of trust

(a) Benefit plan assets to be held in trust; authority of trustees. Except as provided in subsection (b), all assets of an employee benefit plan shall be held in trust by one or more trustees. Such trustee or trustees shall be either named in the trust instrument or in the plan instrument described in section 402(a) [USCS § 1102(a)] or appointed by a person who is a named fiduciary, and upon acceptance of being named or appointed, the trustee or trustees shall have exclusive authority and discretion to manage and control the assets of the plan, except to the extent that—

(1) the plan expressly provides that the trustee or trustees are subject to the direction of a named fiduciary who is not a trustee, in which case the trustees shall be subject to proper directions of such fiduciary which are made in accordance with the terms of the plan and which are not contrary to this Act, or

(2) authority to manage, acquire, or dispose of assets of the plan is delegated to one or more investment managers pursuant to section 402(c)(3) [28 USCS § 1102(c)(3)].

(b) Exceptions. The requirements of subsection (a) of this section shall not apply—

(1) to any assets of a plan which consist of insurance contracts or policies issued by an insurance company qualified to do business in a State;

(2) to any assets of such an insurance company or

any assets of a plan which are held by such an insurance company;

(3) to a plan—

(A) some or all of the participants of which are employees described in section 401(c)(1) of the Internal Revenue Code of 1986 [26 USCS § 401(c)(1)]; or

(B) which consists of one or more individual retirement accounts described in section 408 of the Internal Revenue Code of 1986 [26 USCS § 408]; custodial accounts which qualify under section 401(f) or 408(h) of such Code [26 USCS § 401(f) or 408(h)], whichever is applicable; to the extent that such plan's assets are held in one or more custodial accounts which qualify under section 401(f) or 408(h) of such Code [26 USCS § 401(f) or 408(h)], whichever is applicable.

(4) to a plan which the Secretary exempts from the requirement of subsection (a) and which is not subject to any of the following provisions of this Act—

(A) part 2 of this subtitle [29 USCS § 1051 et seq.],

(B) part 3 of this subtitle [29 USCS § 1081 et seq.], or

(C) title IV of this Act; or

(5) to a contract established and maintained under section 403(b) of the Internal Revenue Code of 1986 [26 USCS § 403(b)] to the extent that the assets of the contract are held in one or more custodial accounts pursuant to section 403(b)(7) of such Code [26 USCS § 403(b)(7)].

(6) Any plan, fund or program under which an employer, all of whose stock is directly or indirectly owned by employees, former employees or their beneficiaries, proposes through an unfunded arrangement to compensate retired employees for benefits which were forfeited by such employees under a pension plan maintained by a former employer prior to the date such pension plan became subject to this Act.

(c) **Assets of plan not to inure to benefit of employer**; allowable purposes of holding plan assets.

(1) Except as provided in paragraph (2), (3), or (4) or subsection (d), or under section 4042 and 4044 [<=11> 29 USCS § 1342, 1344] (relating to termination of insured plans), or under section 420 of the Internal Revenue Code of 1986 [26 USCS § 420] (as in effect on January 1, 1995), **the assets of a plan shall never inure to the benefit of any employer and shall be held for the exclusive purposes of providing benefits to participants in the plan and their beneficiaries and defraying reasonable expenses of administering the plan.**

(2) (A) In the case of a contribution, or a payment of withdrawal liability under part 1 of subtitle E of Title IV [ 29 USCS § 1381 et seq.]—

(i) if such contribution or payment is made by an employer to a plan (other than a multiemployer plan) by a mistake of fact, paragraph (1) shall not prohibit the return of such contribution to the employer within one year after the payment of the contribution, and (ii) if such contribution or payment is made by an employer to a multiemployer plan by a mistake of fact or law (other than a mistake relating to whether the plan is described in section 401(a) of the Internal Revenue Code of 1986 [26 USCS § 401(a)] or the trust which is part of such plan is exempt from taxation under section 501(a) of such Code [26 USCS § 501(a)]), paragraph (1) shall not prohibit the return of such contribution or payment to the employer within 6 months after the plan administrator determines that the contribution was made by such a mistake.

(B) If a contribution is conditioned on initial qualification of the plan under section 401 or 403(a) of the Internal Revenue Code of 1986 [26 USCS § 401 or 403(a)], and if the plan receives an adverse determination with respect to its initial qualification, then para-

graph (1) shall not prohibit the return of such contribution to the employer within one year after such determination, but only if the application for the determination is made by the time prescribed by law for filing the employer's return for the taxable year in which such plan was adopted, or such later date as the Secretary of the Treasury may prescribe.

(C) If a contribution is conditioned upon the deductibility of the contribution under section 404 of the Internal Revenue Code of 1986 [ 26 USCS § 404], then, to the extent the deduction is disallowed, paragraph (1) shall not prohibit the return to the employer of such contribution (to the extent disallowed) within one year after the disallowance of the deduction.

(3) In the case of a withdrawal liability payment which has been determined to be an overpayment, paragraph (1) shall not prohibit the return of such payment to the employer within 6 months after the date of such determination.

(d) Termination of plan.

(1) Upon termination of a pension plan to which section 4021 [29 USCS§ 1321] does not apply at the time of termination and to which this part [29 USCS § 1101 et seq.] applies (other than a plan to which no employer contributions have been made) the assets of the plan shall be allocated in accordance with the provisions of section 4044 of this Act [29 USCS § 1344], except as otherwise provided in regulations of the Secretary.

(2) The assets of a welfare plan which terminates shall be distributed in accordance with the terms of the plan, except as otherwise provided in regulations of the Secretary.

HISTORY: (Sept. 2, 1974, P.L. 93-406, Title I, Subtitle B, Part 4, § 403, 88 Stat. 876; Sept. 26, 1980, P.L. 96-364, Title III, § 310, Title IV, § 402(b)(2), 410(a),

411(c), 94 Stat. 1296, 1299, 1308; Dec. 22, 1987, P.L. 100-203, Title IX, Subtitle D, Part II, Subpart D, § 9343(c), 101 Stat. 1330-372; Dec. 19, 1989, P.L. 101-239, Title VII, Subtitle G, Part V, Subpart C, § 7881(k), Subpart D, § 7891(a)(1), 7894(e)(1)(A), (3), 103 Stat. 2443, 2445, 2450.) (As amended Nov. 5, 1990, P.L. 101-508, Title XII, Subtitle B, § 12012(a), 104 Stat. 1388-571; Dec. 8, 1994, P.L. 103-465, Title VII, Subtitle D, § 731(c)(4)(B), 108 Stat. 5004.)

# APPENDIX H

# TITLE 29 — LABOR
# SUBTITLE B — REGULATIONS RELATING TO LABOR CHAPTER XXV — PENSION AND WELFARE BENEFITS ADMINISTRATION, DEPARTMENT OF LABOR
# SUBCHAPTER B — DEFINITIONS AND COVERAGE UNDER THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974

## PART 2510 — DEFINITIONS OF TERMS USED IN SUBCHAPTERS C, D, E, F, AND G OF THIS CHAPTER
## 29 CFR 2510.3 -3

§ 2510.3-3 Employee benefit plan.

(a) General. This section clarifies the definition in section 3(3) of the term "employee benefit plan" for purposes of title I of the Act and this chapter. It states a general principle which can be applied to a large class of plans to determine whether they constitute employee benefit plans within the meaning of section 3(3) of the Act. Under section 4(a) of the Act, only employee benefit plans within the meaning of section 3(3) are subject to title I.

(b) Plans without employees. For purposes of title I of the Act and this chapter, the term "employee benefit plan" shall not include any plan, fund or program, other than an apprenticeship or other training program, under which no employees are participants covered under the plan, as defined in paragraph (d) of this section. For example, a so-called "Keogh" or "H.R. 10" plan under which only partners or only a sole proprietor are participants covered under the plan will not be covered under title I. However, a Keogh plan under which one or more common law employees, in addition to the self-employed individuals, are participants covered under the

plan, will be covered under title I. Similarly, partnership buyout agreements described in section 736 of the Internal Revenue Code of 1954 will not be subject to title I.

(c) Employees. For purposes of this section:

(1) An individual and his or her spouse shall not be deemed to be employees with respect to a trade or business, whether incorporated or unincorporated, which is wholly owned by the individual or by the individual and his or her spouse, and

(2) A partner in a partnership and his or her spouse shall not be deemed to be employees with respect to the partnership.

(d) Participant covered under the plan.

(1)

(i) An individual becomes a participant covered under an employee welfare benefit plan on the earlier of—

(A) The date designated by the plan as the date on which the individual begins participation in the plan;

(B) The date on which the individual becomes eligible under the plan for a benefit subject only to occurrence of the contingency for which the benefit is provided; or

(C) The date on which the individual makes a contribution to the plan, whether voluntary or mandatory.

(ii) An individual becomes a participant covered under an employee pension plan—

(A) In the case of a plan which provides for employee contributions or defines participation to include employees who have not yet retired, on the earlier of—

(1) The date on which the individual makes a contribution, whether voluntary or mandatory,

or

(2) The date designated by the plan as the date on which the individual has satisfied the plan's age and service requirements for participation, and

(B) In the case of a plan which does not provide for employee contributions and does not define participation to include employees who have not yet retired, the date on which the individual completes the first year of employment which may be taken into account in determining—

(1) Whether the individual is entitled to benefits under the plan, or

(2) The amount of benefits to which the individual is entitled, whichever results in earlier participation.

(2)

(i) An individual is not a participant covered under an employee welfare plan on the earliest date on which the individual—

(A) Is ineligible to receive any benefit under the plan even if the contingency for which such benefit is provided should occur, and

(B) Is not designated by the plan as a participant.

(ii) An individual is not a participant covered under an employee pension plan or a beneficiary receiving benefits under an employee pension plan if—

(A) The entire benefit rights of the individual—

(1) Are fully guaranteed by an insurance company, insurance service or insurance organization licensed to do business in a State, and are legally enforceable by the sole choice of the individual against the insurance company, insurance service or insurance organization; and

(2) A contract, policy or certificate describing the benefits to which the individual is entitled

under the plan has been issued to the individual; or

(B) The individual has received from the plan a lump-sum distribution or a series of distributions of cash or other property which represents the balance of his or her credit under the plan.

(3)

(i) In the case of an employee pension benefit plan, an individual who, under the terms of the plan, has incurred a one-year break in service after having become a participant covered under the plan, and who has acquired no vested right to a benefit before such break in service is not a participant covered under the plan until the individual has completed a year of service after returning to employment covered by the plan.

(ii) For purposes of paragraph (d)(3)(i) of this section, in the case of an employee pension benefit plan which is subject to section 203 of the Act the term "year of service" shall have the same meaning as in section 203(b)(2)(A) of the Act and any regulations issued under the Act and the term "one-year break in service" shall have the same meaning as in section 203(b)(3)(A) of the Act and any regulations issued under the Act.

Supreme Court, U.S.
FILED
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No. 94-2134

# IN THE SUPREME COURT OF THE UNITED STATES

October Term 1994

GEORGE PETERSON,

*Petitioner,*

V.

AMERICAN LIFE & HEALTH INSURANCE COMPANY, CREATIVE HEALTH PROGRAMS; PACIFIC SOUTHWEST ASSOCIATION OF SMALL EMPLOYER FIRMS,

*Respondents.*

On Petition for Writ of Certiorari to the United States Court of Appeals for the Ninth Circuit

## BRIEF IN OPPOSITION TO PETITION FOR WRIT OF CERTIORARI

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## QUESTION PRESENTED

Does the exclusion for bypass surgery in an insurance policy which funds a welfare benefit plan for partners and employees of a business exclude coverage for petitioner's coronary bypass surgery?

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No. 94-2134

In The

SUPREME COURT OF THE UNITED STATES
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GEORGE PETERSON
*Petitioner,*

*vs.*

AMERICAN LIFE & HEALTH INSURANCE COMPANY, CREATIVE HEALTH PROGRAMS; PACIFIC SOUTHWEST ASSOCIATION OF SMALL EMPLOYER FIRMS,
*Respondents.*

# BRIEF IN OPPOSITION TO PETITION FOR WRIT OF CERTIORARI

## I.

## EXCEPTIONS TO QUESTION PRESENTED AND STATEMENT OF THE CASE

Petitioner's Question Presented and Statement of the Case mischaracterizes the factual background. Quivira Marine Service Center was a partnership of which the petitioner was a partner. Quivira Marine Service Center provided health insurance to its partners and employees and further performed administrative duties with respect to maintenance of the insurance coverage. In May of 1989, an

interim policy of insurance was purchased for the partners and employees of the Quivira Marine Service Center because of termination of previous insurance. Thereafter, Quivira Marine Service Center moved coverage for Norman Schultz, an employee, and Walter Gutjar, a partner, to coverage under Blue Cross. The petitioner remained on the AMERICAN policy because he failed a Blue Cross physical. During all times that the petitioner was covered by the AMERICAN LIFE & HEALTH INSURANCE policy, at least one employee of Quivira Marine Service Center was receiving health insurance coverage paid for by Quivira Marine Service Center as the benefit of his employment.

In Petitioner's Question Presented and Statement of the Case, he confuses the formation and maintenance of an ERISA plan with the purchase of an individual policy of insurance. By providing insurance, through whatever policy, Quivira Marine Service Center established an ERISA plan. The mere fact that the petitioner was on a different policy of insurance than Quivira Marine Service Center's employee did not alter the creation, formation, or maintenance of a welfare benefit plan under the applicable provisions of ERISA. More importantly, at all times pertinent hereto, Quivira Marine Service Center provided benefits of insurance to at least one of its employees in addition to petitioner.

## II.
## CONSTITUTIONAL AND STATUTORY PROVISIONS INVOLVED

Petitioner cites to 29 C.F.R. §2510.3-3(c)(2) seeming to imply that a partner in a business with employees cannot fall under the umbrella of ERISA. First, the statute quoted by the petitioner merely says that a partner shall not be deemed an employee with respect to the partnership. The Ninth Circuit ruling in this case does not address whether or not Mr. PETERSON is considered an "employee" of Quivira Marine Service Center. The opinion merely held that, pursuant to previous decisions of the Ninth Circuit, Mr. PETERSON was a "beneficiary" of an ERISA plan. Therefore, the citation made by petitioner is irrelevant.

Furthermore, the quotation cited by petitioner is taken out of context. The previous paragraph, 29 C.F.R. §2510.3-3 clarifies the definition of "employee benefit plan" and who will be covered under such a plan. 29 C.F.R. §2510.3-3(a) & (b), the two paragraphs directly preceding the section relied upon by petitioner states as follows:

> "(a) General. This section clarifies the definition in section 3(3) of the term "employee benefit plan" for purposes of title I of the Act and this chapter. It states a general principle which can be applied to a large class of plans to determine whether they constitute employee benefit

> plans within the meaning of section 3(3) of the Act. Under section 4(a) of the Act, only employee benefit plans within the meaning of section 3(3) are subject to title I.
>
> . . . .
>
> (b) Plans without employees. For purposes of title I of the Act and this chapter, the term "employee benefit plan" shall not include any plan, fund or program, other than an apprenticeship or other training program, under which no employees are participants covered under the plan, as defined in paragraph (d) of this section. For example, a so-called "Keogh" or "H.R. 10" plan under which only partners or only a sole proprietor are participants covered under the plan will not be covered under title I. <u>However, a Keogh plan under which one or more common law employees, in addition to the self-employed individuals, are participants covered under the plan, will be covered under title I</u> [emphasis added]. Similarly, partnership buyout agreements described in section 736 of the Internal Revenue Code of 1954 will not be subject to title I."

The regulation read in its entirety, indeed, supports the previous ruling of the Ninth Circuit on this matter.

## III.
## REASONS FOR DENYING THE PETITION

### A. The Ultimate Disposition of the Case Would not be Altered if Mr. PETERSON were Allowed to Assert Claims Under State Law.

The petitioner, in requesting certiorari, seeks to challenge the ruling by the Ninth Circuit that ERISA pre-empted his claims under state law. However, as was extensively addressed by the Ninth Circuit in their opinion on this case, the outcome for the petitioner would not be any different under state law. As part of petitioner's argument to the Ninth Circuit, he claimed that even though ERISA might grant jurisdiction to the Federal Court, he was still entitled to relief under the "savings clause", which incorporates into ERISA state statutes which "regulate insurance." Petitioner sought to change his group disability insurance policy into an individual policy based on California Insurance Code regulations. The policy was specifically approved as a group policy by the California Insurance Commissioner and the Ninth Circuit explored this argument with petitioner and found it to be meritless.

> "However, we do not believe that, in enacting §01291.5(b)(7), the California legislature intended to permit an insured to reform the nature of his policy and obtain benefits for which he never bargained by engaging courts to second guess the Commissioner's

> approval of a policy as providing 'group' insurance. Regardless of whether the Insurance Commissioner should have approved the policy, an otherwise valid policy is a binding contract and governs the obligations of the party until the Commissioner revokes his approval". (Opinion of the Ninth Circuit, Pages 11-12).

The Ninth Circuit went on to find that the AMERICAN policy was neither vague nor ambiguous and was enforceable according to the tenor of its terms. This interpretation was appropriate since, in essence, this is a claim for payment of medical expenses for bypass surgery from an insurance contract which excludes bypass surgery as one of the covered benefits.

As this court is well aware, there is more to consider in deciding whether or not to grant certiorari than a mere split in the Circuits. There should be "special and important reasons" for the granting of petitioner's writ, Supreme Court Rule 10.

Because Mr. PETERSON's claim would not be decided any differently under state law, the decision as to whether or not ERISA pre-empts his claim is moot.

**B. Petitioner Exaggerates the Nature of the Split in Jurisdictions.**

Although respondent concedes the opinion in Fugarino v. Hartford Life & Accident Insurance Co., 966 F.2d 178 (6th

Cir. 1992, Cert. Denied 113 S. Ct. 105, 112, L. Ed. 774 (1993), directly conflicts with the Ninth Circuit's holding in this case, many of the other cases relied upon by the petitioner are not in direct conflict with the Ninth Circuit's ruling. Most especially, in Turnbow v. Pacific Mutual Life Insurance Comapany 765 P.2d 1160 (Nev. 1988), the Nevada Supreme Court decided that there was insufficient evidence of an ERISA plan established by the employer. Since the court did not find an ERISA plan, its opinion with respect to who qualifies as a proper ERISA plaintiff is moot and by definition dictum.

> "We conclude that the District Court erred in finding that the appellant had created an ERISA plan. Appellant did not create an ERISA plan. Unless there is some indication that an employer is committed to or has guaranteed the continuation of such benefits, nothing is created for ERISA to protect and no plan exists." Turnbow supra. at 1161.

In National Mutual Insurance Co. v Darden 503 U.S. 818, 112 S. Ct. 1344, 117 L. Ed.2d 581 (1992), an insurance company's former agent brought an ERISA action to recover alleged retirement benefits. The issue in that case was whether a salesperson who was hired as an independent contractor was an employee within the definition of ERISA. The issue in Darden has no bearing on whether a owner of a business can also be a beneficiary of an ERISA plan.

In Meredith v. Time Insurance Co. 980 F.2d 352 (5th Cir. 1993), the issue was whether a sole proprietor without employees is a proper ERISA plaintiff. Although the court in Meredith held that such an individual was not a proper ERISA plaintiff, the court seems to imply that had there been employees also covered under the benefit plan, then the result might have been different.

> "Under the controlling definition, Meredith is not an employer because she has no employees and plans without employees are, by definition, not regulated by ERISA." Meredith supra. at 358.

Petitioner also relies extensively on District Court opinions which do not necessarily demonstrate a split in the judicial circuit. The impact of the District Court opinions are not left to the Appeal Courts of the circuits.

## IV.

## CONCLUSION

Petitioner and assistants purchased a policy of insurance through his jointly owned business which provided similar insurance benefits to employees of the business. The policy of insurance in this case specifically excluded bypass surgery. Both the District Court and the Ninth Circuit Court of Appeals have determined that the policy was clear and unambiguous. The petitioner now requests to continue to prosecute this action claiming benefits for expenses in

connection with his bypass surgery. Under any forum or jurisdiction, the case involves a clear, unambiguous insurance policy, which both the District Court and the Ninth Circuit Court of Appeals have determined does not confer any claim for benefits on the petitioner. Therefore the petitioner's request for Certiorari is moot and should be denied.

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Respectfully submitted

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